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Public Administration
Select Committee

Choice, Voice and Public Services

Written Evidence

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The Public Administration Select Committee

The Public Administration Select Committee is appointed by the House of Commons to examine the reports of the Parliamentary Commissioner for Administration, of the Health Service Commissioners for England, Scotland and Wales and of the Parliamentary Ombudsman for Northern Ireland, which are laid before this House, and matters in connection therewith and to consider matters relating to the quality and standards of administration provided by civil service departments, and other matters relating to the civil service; and the committee shall consist of eleven members.

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Committee staff

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List of written evidence

An Issues and Questions Paper

INTRODUCTION

PASC - the Public Administration Select Committee - is undertaking an inquiry into choice and voice in public service reform as part of its wider scrutiny of the Government's programme of reform.

The historical context for the current debate on public service reform goes back at least as far as the 1945 "settlement", brought about principally through the creation of the welfare state. This saw the establishment of a broad consensus that whole new areas of activity which had previously been in the private sector should now be regulated or directly owned by the state in the public interest to secure efficiency and equity. The 1960s and 70s began to see a breakdown of this consensus. It was followed in the 1980s by a determined attempt by Government to withdraw from large areas of state control or intervention in favour of a more market led approach.

Variations to the post-war model of central provision of public services have involved either internal contracts, benchmarking and performance-related pay across the public service (developments most often associated with the creation and development of executive agencies); or competitive tendering and contracting for defined, often stand-alone, services from cleaning to IT or certain administrative functions. Both of these approaches are relatively well established now as part of public service performance culture. The third, less developed, variant is choice: allowing individuals to choose from among alternative suppliers, whether or not entirely within the public sector.

Choice in Public Service Reform

The concept of public service users enjoying certain minimum rights predates the current administration and was most clearly encapsulated in the award system of the Citizens' Charter. However it was after the election of the Labour Government in 1997 that the idea of citizens also being consumers of public services (and that those services should therefore become increasingly customer focused) gained greater currency.

In March 1999 Modernising Government (Cm 4310) set out the Government's plans for reforming the machinery of government. One of its five key commitments was to have responsive public services which would meet the needs of citizens rather than the convenience of service providers. The document also declared "People are exercising choice and demanding higher quality. In the private sector, service standards and service delivery have improved as a result. People are now rightly demanding a better service not just from the private sector, but from the public sector too".

In June 2001 the Office of Public Sector Reform (OPSR) was set up. Its Head, Wendy Thompson, has stated that, specifically, its job is to improve current structures, systems, incentives and skills with the aim of ensuring "the delivery of truly customer focused public services".

In October 2001, in a speech on public service reform the Prime Minister declared that, "the key to reform is redesigning the services around the user – the patient, the pupil, the

passenger, the victim of crime". He then enunciated the four key principles of reform: national standards and accountability; devolution to the front line; diversity and promotion of alternative providers and greater choice. "All four principles have one goal – to put the consumer first".

The 2002 OPSR publication "Principles into Practice" elaborated further on these four principles. In the foreword the Prime Minister said that choice "acknowledges that consumers of public services should increasingly be given the kind of options that they take for granted in other walks of life".

In June 2003, in the inaugural Fabian Society Annual Lecture, the Prime Minister described his first six years in Government as having been essentially about making up for the "Progressive Deficit". He then went on to say that this progressive deficit was greatest in the area of public services as a result of years of underinvestment, inequality and lack of responsiveness. In opening up the system away from a uniform provision to a diverse and flexible one the Prime Minister claimed the public wanted "the consumer power of the private sector, but the values of the public service"

Most recently, on **29 January, in a keynote speech at a conference on public services** the Prime Minister defined the aim of reform as being "[…] modern social justice to ensure the values of public service – equity, universality, public accountability – not only survive but thrive in a world of rapid change, of increasingly complex needs and of ever more demanding people". He set out the strategy for continuous improvement in public services in simple terms: by giving power to the people through greater choice, greater "voice", more personalised services and partnership. Standards are to be driven up by the knowledge that consumers can go elsewhere. This choice and "contestability" of services is based not on individuals' wealth but on the equal status of each citizen.

VOICE

Complaints as a formal means of improving services and obtaining redress is now well-established in the public sector although, as evidence from the Ombudsman to this Committee shows, it less than perfect in its application across the whole of the public services. Complaints as a means of raising standards, however, raises some problems. For example, low income or vulnerable groups may be the least likely to complain or be put off by fear of recrimination. Those best placed to complain, often the better-off and the better educated, may as a result, distort the system in their favour.

The Prime Minister elaborated on the Government's concept of 'voice' in the public sector in his 29 January speech. He defined it to mean "direct user engagement whether in school governing bodies, Foundation Trust Boards, tenants forums". He explained that this was not an attempt to supplant local government, but to enhance it but added that, "voting is a blunt tool for the expression of complex opinions and detailed preferences". There was a need to explore how a stronger voice for the public could be provided in new areas with more decentralised decision making to community level.

RESOURCES AND CAPACITY

Extending user choice through services which may be increasingly tailored or personalised inevitably gives rise to questions about how they are to be resourced. If individuals are to exercise genuine preference, the implication is that there must be sufficient, or even some excess, capacity within public sector provision. In turn this means an expansion of those facilities which face a higher demand such as certain schools or hospitals and the influx of additional suppliers from the voluntary and private sector or even overseas.

Footing the bill for new or additional services may also mean shifting the burden away from the tax payer to the users of those services as has become increasingly the case in areas such as higher education or, more directly, through the introduction of tolls for new motorways. In his 29 January speech the Prime Minister gave an assurance that there was "no secret plan for us to abandon the principle of free universal public services where they now exist". He went on to say however that in looking to create "new opportunities and providing new services […] there will have to be a debate about the right balance of funding". In terms of capital costs the Chancellor, in his speech to the Social Market Foundation last year saw no principled objections to the extension of private finance initiatives into new areas in certain circumstances.

APPLICABILITY OF CHOICE

For public service providers to offer real choice implies identifying who their customers are, what they require and how best to provide it. This consumerist approach may not be universally applicable to the whole range of government functions. Moreover the provision of some of those services (such as refuse collection, personal social services or, in the case of the train passengers, in the form of newer concepts of public interest companies, strategic authorities and private operators) may lie outside the direct control of central government. There may also be services which, although in principle lending themselves to the exercise of consumer preference, in practice it may simply be inappropriate to do so, for example in the case of the police or fire service. In such cases, reconciling the interests of consumers with the public interest is likely to prove a complex balancing act.

CHOICE AND EQUITY

Concerns exist however about the prospect of further development of an approach to public services where consumer demand is the principal determinant. In practical terms the main concern is that greater choice and diversity will create inequalities within sectors of public service and across different parts of the country. Implementing choice may also be problematic with regard to equity if it were to be the case that additional, new or improved services were to be funded by some form of user charge outwith general taxation. Choice also implies an ability by consumers to "shop-around" and therefore that they will have the information necessary to enable them to do so. The potential drawback is that if certain, more vulnerable, groups in society are unable to access adequate information, the system will favour the "information-rich" – usually the more prosperous people in society.

More widely there is concern too that public services are not easily equated with the private sector. In a speech last year on public services, the Chancellor of the Exchequer suggested that the consumer cannot be sovereign in healthcare because of its unpredictable nature.

The quality of public services is judged not only through personal experience, of the NHS or the education system for example, but also through perceptions of their overall performance at national level. Moreover the policy intentions behind the provision of public services may be complex. It may not simply be about delivering a better product more efficiently but also about promoting certain public values, or protecting public goods like the environment. Associated with this is the risk that active and participative citizens will be undermined by an excessive concentration on individual consumers who may perhaps harbour unrealistic expectations of the public service, and whose aggregated choices may not necessarily add up to the public good.

In his 29 January speech the Prime Minister firmly rejected the notion that choice is detrimental to equity. First, because it ignores the fact that the uniformity of the old monopolistic, paternalist model of public services did not yield equality. The uniform system was inequitable and middle Britain has been the overwhelming beneficiary of the better schools, hospitals and other public services. It is also seen as patronising poorer people, implying that they are not capable of making informed choices. Instead by tackling exclusion and supporting people through the system, he believed choice and what he called "personalisation" can benefit everyone. He cited as an example the development of the personal adviser role (in Job Centres, for instance) as an important feature of reform.

THE COMMITTEE'S INTEREST

PASC has long had an interest in the effective delivery of public services, expressed in reports in successive sessions, **Making Government Work, the Emerging Issues** (Session 2000–01, HC 94); **The Public Service Ethos** (Session 2001–02, HC 263) and **On Target? Government by Measurement** (Session 2003–03, HC 62).

'Making Government Work' examined the machinery of government and the organisation of public services, with a particular emphasis on the progress of the Modernising Government initiative. It stressed the need to ensure that organisational targets encourage "joined up government" and outcomes rather than outputs.

The Public Service Ethos', the first product of the Committee's overarching inquiry into the Government's programme of public service reform, looked, among other things, at the question of private involvement in service delivery. It recommended that the Government should require all public service contracts to include a public service code which would enshrine and promote values of ethical propriety, democratic accountability and fairness as well as excellence in service quality.

"On Target? Government by Measurement" recommended a radical reform of the measurement culture: fewer, more high-level priorities for Government, greater local autonomy to set meaningful targets, wider consultation involving professionals, service users and Parliament, and a move away from the simplistic win or lose approach. It also advocated a credible, independently validated annual performance assessment. The Government response was positive and pointed out a number of ways in which departments were already seeking to introduce greater autonomy for the "front line" of public services.

HOW TO RESPOND TO THIS PAPER

PASC would like to receive responses to any or all of the questions in this paper. Although some of the questions could theoretically be answered by a simple yes or no, the Committee would especially value extended memoranda with background evidence where appropriate. **Some respondents may wish to concentrate on those issues in which they have a special interest, rather than necessarily answering all the questions.**

Memoranda will usually be treated as evidence to the Committee and may be published as part of a final Report. Memoranda submitted to the Committee should be kept confidential unless and until published by the Committee. **If you object to your memorandum being made public in a volume of evidence, please make this clear when it is submitted.**

Memoranda should be submitted by 16 April 2004 as hard copy on A4 paper, but please send an electronic version also, on computer disk in Rich Text Format, ASCII or WordPerfect 8 or email to pubadmincom@parliament.uk. Hard copies should be sent to Clive Porro, Second Clerk, Public Administration Select Committee, Committee Office, First Floor, Committee Office, 7 Millbank, London SW1P 3JA.

QUESTIONS

Defining what choice means in the public sector

1. How is choice in public services to be defined?

2. Will the nature of choice vary depending on the type of provision or service?

3. Is "choice" simply a euphemism for competition and market mechanisms?

The concept of customers of public services.

4. Is it possible to have customers of public services as well as active citizens and democratic accountability or are they mutually exclusive?

5. Is it necessary to devise a more precise and generally acceptable definition of who the user or customer for each service is? For example is it the pupil who is the user of the school system when it is the parent who exercises the choice?

6. Is it possible to identify a customer for the entire range of government functions or is it limited to public facing activities as envisaged, for example, in the Next Steps approach of the late 1980s?

Mechanisms for expressing choice

7. Are targets and league tables, customer surveys and complaints systems sufficient for ensuring adequate responsiveness to consumer preferences?

8. Is contestability a further requirement to make choice fully responsive? If so to what degree?

9. Can individual choice, collective choice and choice on behalf of the citizen (by Government or Local Authorities for example) operate successfully alongside each other?

10. Are all these forms of choice equally effective in ensuring a) efficiency and responsiveness and b) equity and fairness?

Choice and equity

11. Is there a generally understood definition of what equity means in respect of public services? Does equity currently exist in public service provision? If not who have been the main beneficiaries and why?

12. Must there necessarily be losers in a system involving choice and contestability?

13. How can a choice-based provision of public services avoid providers "cream-skimming" the less difficult or resource intensive users of the service?

Information for users

14. To what degree is the ability to evaluate different providers necessary for consumer choice?

15. How should those users less able to make informed choices because of their income or situation be empowered to do so? What form should the provision of information take?

16. How is satisfaction with and the performance of services to be measured, by whom and how is that information to be made available?

Voice and public services

17. What mechanisms (complaints, feedback) exist or should be created for exerting influence on providers? Are they available to all?

18. Does the complaint system operate effectively and equitably in the public sector? If not what should be done to improve this?

19. Is decentralised decision making and "direct user engagement" an expression of "new localism" or will it lead back to a Victorian-style future of education, health or sanitation boards of the local great and good?

Devolution and diversity

20. At what levels can choice and voice operate within public service provision? Do they reinforce greater localism and devolution?

21. Is diversity a prerequisite for choice? If so does diversity refer to good and bad performers or to the requirement for some unique selling point from the provider such as faith or specialist schools?

22. Does choice risk reinforcing the so-called "postcode lottery"?

Choice and the public good

23. Can the consumer be "sovereign" in the public services? If not, why not?

24. Is there a risk that a consumerist approach to public services will undermine the public service ethos?

25. Does the creation of individual consumers for public services put social cohesion and the idea of the public good at risk? If so what alternatives are there to the consumer choice agenda for public service reform?

Capacity in the public services

26. Will the extension of choice create unmanageable demands on the capacity of public services to provide? If so is some degree of excess capacity necessary for choice to operate effectively?

27. What are the cost implications of this? Should it lead to an extension of Private Finance Initiatives?

28. Are user charges an inevitable outcome of greater choice? Might user charges help widen choice?

29. Would enforcing equity in a co-funded, choice-driven system imply a proliferation of regulators on the model of the Office of Fair Access for the universities?

Raising standards

30. What is the nature of choice within a framework of uniform standards?

31. How can an individual's choice enhance national standards and accountability?

Evidence base

32. Is there already sufficient evidence, research and experience to judge the effect of greater choice on equity in public services?

33. Does the functioning so far of parental and patient choice support the argument that it promotes equity?

34. Are there lessons which can be learned from other countries and if so are they readily applicable here?

Written evidence

Memorandum by the Sainsbury Centre for Mental Health (CVP 01)

Introduction

The Sainsbury Centre for Mental Health is an independent mental health charity, working with the NHS and social services across the UK to improve the quality of care they provide to people with severe mental health problems.

Promoting choice and empowerment among service users is at the centre of our work. We have championed changes in policy and practice to bring this about in recent years. This response draws upon our experiences of the reality of working with a whole range of public services to promote the interests of those with mental health problems. It follows the question headings used in the Issues and Questions paper.

Defining What Choice Means in the Public Sector

The Sainsbury Centre for Mental Health broadly welcomes the extension of choice in the NHS beyond acute hospital services and into areas such as chronic illness and mental health. There is no reason choice should be any less accessible for people with mental health problems as for those with other illnesses. However, choice in mental health care will inevitably be constructed differently to other areas because, for example:

- Many people come into the system compulsorily—they do not have an option of exit;
- Most services are organised geographically—community services are limited to specific areas so choosing between them is not an option.

For these reasons, in our response to "Fair for all, personal to you", we set out what we believe are the five key principles underlying choice in mental health care. They are:

1. There must be a commitment to develop the kinds of services users actually want. Choice should not be about selecting from a set menu of existing services or alternative suppliers of the same thing. It should be about redesigning services around the stated wishes of those who use them and their carers.

2. Clear and accessible information is vital for people to express and act upon their preferences. Services have to ensure that there is provision for advocacy to support to those who are using services. There have to mechanisms for feedback on the acceptability and quality of services so that there can be continuous improvement.

3. Choice and responsiveness must be available from the point at which people first seek help for a mental health problem. Many people currently wait for too long to get help. Others find services unhelpful and do not seek help until they are very ill.

4. People with mental health problems should be enabled to exercise choice not merely in the kinds of treatment they get but in the way they get back their lives. That means offering people genuine choices about the support they get with education and employment, social networks, housing and other aspects of their lives that matter to them.

5. A commitment to equity requires a degree of fairness between different health services. This implies a reasonable commonality of standards in every dimension of the patient experience both between as well as within services. This underlines the need for substantial development in mental health services.

The Concept of Customers in Public Services

Even in mental health services, where much care is provided compulsorily in secure hospitals and forensic units, it is not impossible to empower service users sufficient that they become, if not customers, clients of the service. Advance directives, used increasingly in a range of public services, have a lot of potential in mental health care given the episodic nature of many mental health problems. Easy access to advocacy, especially for people from disadvantaged groups and those in inpatient units, is also a vital mechanism for the exercise of choice.

The concept of patient as customer has been a driving force of the patient choice initiative in NHS elective surgery—offering people who have waited too long for their local hospital the opportunity to choose where they have their operation. An equivalent system could be set up in mental health care, where waiting times for services such as psychological therapy and counselling remain very long. This would require the introduction of a waiting list for such services.

Mechanisms for Expressing Choice

It is vitally important that public services involve and engage with people both as citizens and as service users. In the case of the NHS, the public previously influenced policy only through national Parliamentary elections. This has been supplemented by the patient choice initiative, at the individual level, and a number of reforms at the collective level including the development of user involvement in service planning, the new role of local authority overview and scrutiny committees in the NHS and, soon, the creation of Foundation Trusts. Each of these brings a different aspect of the public voice to services and has its own, distinct value.

None are adequate on their own. This is why SCMH supported moves to ensure Foundation Trusts were each required to maintain a Patient's Forum as well as their boards of governors. It will also be important for them to build on their growing connections with local authorities, not to bypass them and focus only on their own constituencies.

Choice and Equity

Simply creating the opportunity for clients to have choice in public services is not enough to ensure it is applied equitably. It requires fundamental changes to the way those services work and investment in support systems to enable people to make informed choices. Three connected types of action are required to promote equity in choice:

1. Information provision: clear, accessible information about the service, available both at the first point of access (eg GP surgeries, A&E) and in other locations (eg public libraries and the internet).

2. Workforce training and development: a wide range of staff in public services need support to ensure they are well equipped to explain what choices people have and facilitate (not impose) their decision-making. A recognition that clients' values may be different to their own is one important facet of staff training in public services.

3. Advocacy: for disadvantaged groups in particular, and mental health service users in general, advocacy will be the key to accessing appropriate services and making choices. For many people advocacy is the route to empowerment. But the quality and quantity of advocacy available around the UK is patchy: it requires considerable investment before we can be sure effective advocacy is being offered equitably.

Information for Users

Satisfaction with services can be gauged in a number of ways. In our experience of mental health services, one of the most effective methods is by supporting groups of service users to carry out their own evaluations. To this end, we developed a methodology of User-Focused Monitoring (UFM). Through this method, service users are offered the training and resources to carry out research among their peers and gauge satisfaction with the service. More details are available on the SCMH web site.

Voice and Public Services

Mental health services are often at the forefront of efforts to involve service users in the public sector. An SCMH survey last year of more than 300 service user groups in the UK found that the majority are now actively involved in planning and monitoring local services. There remain serious concerns about their ability to do this—the majority of groups have very little infrastructure and most rely on enthusiastic individuals to meet the demands placed upon them. Investment in the capacty of existing service user groups, as well as the creation of new structures for user involvement, is essential for involvement to be meaningful and effective. This is not unique to mental health care though is probably better developed here than in many sectors.

Devolution and Diversity

Increased diversity of provision is essential for genuine choice. Mental health service users want not merely access to medication and "talking therapies" but a whole range of services from complementary therapies to advice on employment and benefits.

The voluntary sector is often where innovations in practice emerge. For people from some black and minority ethnic communities in Britain, mental health services are experienced as coercive and inhumane. Many people choose instead to look to their own community groups to provide care and support. Numerous African and Caribbean community groups and churches provide services such as advocacy, help with finding a job, creative arts activities or just somewhere to go where people feel safe.

The public sector could do more to support and develop the role of voluntary and community groups. Secure funding and help with core costs are all important. Without it, voluntary groups cannot compete on a level playing field with public or commercial providers.

Many voluntary groups provide both direct service provision and an advocacy/campaigning role. This balance is important to maximise the benefits they can bring to their communities and client groups. It means developing a relationship which tolerates such groups "speaking out" about problems while also working on contracts with public services.

The Supporting People programme is also beginning to encourage greater innovation in the provision of housing-related care services. It would be a cause for concern if reductions in the budget for Supporting People damaged the growing diversity of these services, especially those run by the voluntary sector.

Capacity in the Public Services

Increasing choice may, on some measures, reduce efficiency within public services. It is inevitable, for example, that some kind of spare capacity is needed within the system to make choice work for users. But it is even more inefficient to be providing services that people do not want or that do not benefit them.

In move-on housing for people leaving mental health hospitals, for example, choice is vital to ensure people live somewhere that is appropriate to their needs (social and cultural as well as medical) and located in an area where they feel safe. Offering that choice depends on the following:

- A number of places being made available from which to choose;
- A variety of places in existence to meet diverse needs (eg for different religious groups);
- The chance to have a trial period in a new home.

All of these conditions presuppose that there is some degree of under-occupation of facilities and that public services work together in a flexible way, around the needs of the person. Although this has cost implications, without it choice cannot be attained unless there are severe delays to discharges from hospital (which is even more inefficient for the service as well as being inappropriate for the client).

While some public services may need additional capacity to facilitate choice, it is even more important that they use their resources (staff included) more flexibly.

Raising Standards

If choice is implemented effectively, it can have a dramatic impact on the quality of services. In the mental health field, for example, this could be achieved in a number of ways:

- Extending direct payments—enabling individuals to influence what services are provided by purchasing for themselves the services they find useful and appropriate;
- Widening person-centred planning—building local services according to the collective wishes of service users: a technique which has been implemented in learning disability services and could be used elsewhere;
- Instituting user-focused monitoring—empowering service users to carry out their own research into services, influencing their development by collating their peers' views about what exists currently and how it could be improved;
- Building up evidence—involving service users in the work of inspectorates (eg The Healthcare Commission) and best practice agencies (eg National Institute for Clinical Excellence).

Such improvements are much needed. Many mental health hospitals are located in outmoded Victorian buildings where privacy is impossible, harassment is commonplace and facilities are poor. No one would ever choose to be treated in such an environment.

In such cases genuine choice relies on the existence of a better alternative to which public service clients have access and where it leads to investment where clients have said it is most needed. And it means that services which are not currently receiving their fair share of resources will need to be targeted to ensure that the choice initiative does not only benefit those in the relatively well-resourced areas of the public sector.

April 2004

Memorandum by Professor Ron Glatter (CVP 02)

CHOICE AND DIVERSITY OF SCHOOLING PROVISION: ISSUES AND EVIDENCE

Summary and Relationships to the Committee's Questions

This paper offers a brief review of evidence and key issues relevant to choice and diversity in the maintained secondary school sector in England since the mid 1990s[1].

It focuses in particular on the Committee's question 21, about the relationship between diversity and choice. It suggests that, despite a strong focus on choice and diversity in schools policy over more than a decade, the precise connection between them is very little understood and needs much closer attention. The relationship between them appears subtle and ambiguous. Just as choice does not necessarily lead to greater diversity, so diversity may not produce perceptions of increased choice. For example it is not self-evident that defining school missions more sharply in terms of subject specialisation will lead to a perception of enhanced choice among families of 10-year old children. The perception could instead turn out to be one of reduced choice, particularly among the many families in all types of area (not just rural ones) who consider that their realistic choice of schools is very limited. Families may also perceive unwelcome pressure to form a judgement about their child's aptitudes at an early age.

Current policy on school diversity is heavily focused on one specific and arguably narrow form of diversity, namely subject specialisation. There are also indications of a "pecking order" of specialisms developing which could reinforce existing hierarchies.

The paper also addresses aspects of questions 30–33, concerning choice and national standards and choice and equity. There has been a large body of research on school choice. There is little evidence that choice has led to improved educational outcomes, while the context of uniform standards and the need to appeal to a broad "market" has on the whole discouraged schools from voluntarily seeking to differentiate themselves sharply. With regard to choice and equity, there is some disagreement but overall it appears that any tendency towards greater polarisation may often have been blunted by the influence of other factors such as demography or school reorganisation. The wide variety of local contexts and the many ways the various influences play out within them make generalisation hazardous.

Finally the Committee does not appear in its questions to have raised the issue of demand. There is a puzzle about policy-makers' intense and continuing interest in between-school choice and diversity when there is no evidence of a widespread demand for them from the public. Parents generally appear to be simply looking for a school which will deliver the "standard product" well, though this could change were a range of more distinct school types to become available.

1. *Choice*

The principal elements of the education quasi-market in England introduced by the Conservative government's Education Reform Act of 1988 have frequently been described (for example: OECD, 1994; Whitty *et al,* 1998; Tomlinson, 2001). There was a considerable extension of parents' rights to choose a state school for their child ("more open enrolment"). Schools became funded by formula based largely on the number of pupils on roll and were required to manage delegated budgets including staff salaries. Crucially these market-based measures were complemented by a strong form of performance regulation, including a national curriculum, frequent testing and the publication of school test and performance tables. A national system of regular inspections controlled by a government agency, the Office for Standards in Education (Ofsted), was instituted in 1993.

The Labour government first elected in 1997 has retained the essential elements of this system. "The main structures of the quasi-market are still in place—parental choice, open enrolment, funding following pupils, school diversity and publication of league tables" (West and Pennell, 2002, p 218). It has however made some adaptations. For example, the market emphasis is being enhanced through encouragement for successful and popular schools to expand and to take over weak and "failing" schools (Blair, 2002). On the other hand there is now increased regulation of the school admissions process through a code of practice and an adjudication system. Projects such as "Excellence in Cities" (DfEE, 1999) designed to target resources to areas with high levels of disadvantage have been established. Value added measures have been introduced to school performance tables. There is a strong emphasis, which was not present under the Conservatives, on partnership and the sharing of expertise between schools. Perhaps of particular significance is a much enhanced focus on school diversity, particularly through a large expansion in the number of specialist schools: "This greater diversity is good for pupils and parents and will ensure there is more choice and

[1] This is a slightly adapted and updated version of my background paper "School choice and diversity in England: a brief overview of research and key issues" submitted to the Education and Skills Committee inquiry into diversity of provision in secondary education (House of Commons Education and Skills Committee, 2003). It has formed the basis for my contribution to Hirsch *et al,* (2004, in press), an article on school choice and diversity with an international focus, with special reference to England and New Zealand.

innovation in the school system" (Morris, 2001, p 7). The rationale for this emphasis on diversity and innovation may be understood from a brief discussion of one of the major research studies of the operation of the quasi-market under the Conservatives.

A substantial longitudinal (1991–96) project—the Parental and School Choice Interaction (PASCI) study (Woods *et al*, 1998)—contained three inter-related sets of findings of particular relevance to subsequent policy.

First, the study noted a tendency for schools to "privilege" the academic aspects of their provision as a response to more market-like conditions. This appeared to be less a reflection of parental preferences, since most parents do not emphasise the academic over and above personal and social factors, than of the policy environment which provides strong incentives in this direction through, for example, the published performance tables accentuating academic performance. Second, the tendency for schools in England to appeal to a broad grouping of potential parents and pupils rather than to differentiate themselves sharply in order to focus on a specific niche, noted in the OECD's (1994) report on school choice in six countries, was confirmed. This tendency towards homogenisation arose both from central prescriptions such as the national curriculum and also from market incentives promoted by *per capita* funding and more open enrolment. Third, and closely connected to both the previous points, there was little evidence that the competitive arrangements established in England in the 1990s had encouraged innovation within the system. Where innovation did take place it was running counter to the centralising trends of policy, and there were indications of it being curbed sometimes by a reluctance to appear to step outside the dominant model of the high status school.

These are of course broad generalisations drawn from the detailed study and need to be understood as such. We will return later to the issues raised by the findings.

In the later 1990s the English research on choice became increasingly quantitative, including attempts to probe the connection between the competitive system and educational outcomes. The PASCI study had already found that the most consistent improvement in exam pass rates over a four-year period took place in the least competitive of its three case study areas, which was in a semi-rural location. However, a later study based on a more quantitative methodology found some evidence of a link between degrees of competition in local areas and rates of examination improvement over time (Levačić, 2001). In a sample of over 300 schools, a statistical association was found between heads perceiving that they were in competition with at least five other schools and performance in the "headline" performance measure of five or more grade A* to C in the General Certificate of Secondary Education (GCSE) examination. The author suggests that "this is due both to greater stimulus to improve and maintain the school's position in the local hierarchy and to more opportunities for co-operation and emulation related to product quality" (*ibid,* p 40). However, as the author indicates, the finding must be interpreted with caution. First, another key indicator—the degree of competition as perceived by the head—was not found to be associated with performance improvement. Second, it relates to only one performance measure: the limitations of this particular measure as an indicator of the achievement of all pupils in a school have been widely recognised, despite the political significance that has been accorded to it.

Gorard and his associates pursued a different issue through quantitative analysis: whether choice and competition increases polarisation. Analysing data for every state-funded school in England and Wales over a 12-year period, they found that overall segregation in terms of poverty had declined between 1989 and 2001: although it began to rise after 1997, in 2001 it remained below the 1989 level (Gorard *et al,* 2002a). They attributed this finding to three sets of factors:

- local social geography, such as the pattern of local housing;
- school organisation at a local level, including closures and mergers of schools (which tend to decrease local segregation) and selection and school diversity (where higher levels of segregation tend to be found); and
- school admission systems.

With regard to the latter, the authors' data suggest that local education authorities (LEAs) which use catchment-area based systems, and LEAs in which a large proportion of schools are their own admission authorities (such as voluntary-aided and foundation schools) have higher levels of segregation. One of the authors' overall conclusions is that "Choice policies do not appear to have either the clear benefits their advocates had hoped or the dangers of segregation their opponents feared" (*ibid,* p 36).

This study has generated a bitter academic and methodological dispute. For example Gibson and Asthana (2000) published data indicating that, within local markets, initially high-ranking schools have been drawing to themselves the most advantaged pupils and improving their GCSE performance fastest. They claim this gives solid support to the thesis that competitive markets in schooling promote social polarisation. Noden (2000) criticised the Gorard *et al* study for using an inappropriate measure of segregation and proposed an alternative. Using his alternative as well as Gorard's measure he concluded that there had been a slight increase in social segregation between 1994 and 1999.

From a smaller-scale study of the secondary school transfer process in London, Noden *et al* (1998) found that middle-class families gained access to significantly higher scoring schools in terms of GCSE passes. There was little evidence that this was due to where they lived ("selection by mortgage"), but appeared to

be because they could afford to travel further in order to flee low-scoring inner city schools and because some schools had adopted admissions policies favouring more privileged applicants. More recently a government-sponsored survey of parents' experience of school choice drew attention to the role of cultural capital as a resource for promoting access to desired schooling (Flatley *et al,* 2001). Better-educated mothers were much more likely than others to say they knew how pupil allocations to popular schools were carried out. Owner-occupiers and mothers of white ethnic origin were also particularly likely to assert that they understood the technicalities of the allocation process. This study also indicated that parents in London were least likely to be offered a place in the school they most wanted (nearly 70% compared with 85% nationally). London parents were also less likely to apply to their nearest school than those living in other areas (including other urban areas) and they were the least satisfied with the outcome of the application process.

From this necessarily brief and selective review of the substantial body of research on school choice in England, some general points might be made. There are evident methodological difficulties involved in investigating the effects of such a complex set of policy developments. These difficulties are rendered more acute when other reforms, some of which were intended in part to counteract the impact of marketisation, were being introduced at the same time, and when the changes themselves were and remain the subject of intense ideological debate. This cluster of factors may explain why the research results do not point unequivocally in one direction, for example over the question of polarisation. However an alternative explanation may be that even policy changes that appear radical when they are first proposed and implemented may have a much more limited impact than expected because of deep-rooted social and geographical factors and because of coterminous trends and forces that operate to reduce their effect. For example, Gorard *et al,* (2002b) found no evidence of the predicted school "spirals of decline", attributing this finding to school rolls being higher than they would otherwise have been because of a rising school population and school closures and mergers during the period in question. Despite his criticisms of the Gorard methodology, Noden makes a similar general point: "The sustained population loss from some declining urban areas, and in particular the loss of more advantaged families, may be of greater importance to changes in the social mix of local schools than any 'within-LEA' quasi-market effects" (Noden, 2000, p 383). Subsequent research and analysis have tended to confirm Gewirtz *et al'*s assessment in their pioneering study carried out in the early 1990s: "The diversity of local settings and the particularity of their politics, social geographies and histories make it difficult to generalise about market forces in education" (Gewirtz *et al,* 1995, p 57).

2. *Diversity*

The Labour government has put great emphasis on an enhancement of school diversity, arguing that "each school should have its own ethos and sense of mission" (DfES, 2002, p 17) to combat the excessive uniformity which they claim the existing comprehensive system developed since the 1960s has promoted. However the research referred to above suggests that the reforms initiated by the 1988 Act were particularly strong drivers of uniformity and homogenisation.

This greater diversity is being achieved in large measure through a major extension of the Conservatives' "experiment in specialisation" through plans to quadruple the number of specialist secondary schools between 2001 and 2006 which would mean the majority of secondary schools having a stated specialism. Eventually specialist school status would be available to all schools that can submit convincing applications. Secretary of State Charles Clarke has said that ". . .Specialist schools lie at the heart of our drive to raise standards and offer more choice in secondary schools" (DfES, 2002b) and the aim is to create "a new specialist system" (Department for Education and Skills, 2003). The specialisms that schools can bid for have been extended from technology, languages, sport and the arts to include engineering, science, "business and enterprise", "mathematics and computing", music and humanities. These schools have to set and meet targets in the specialist area and raise business sponsorship for a relevant project: they receive additional government grants, including an element for co-operation and sharing of expertise with other schools.

Diversity has also been promoted by providing encouragement for schools supported by the churches and other faith groups. A few Muslim, Sikh and Greek Orthodox schools have been brought inside the state system and are funded as "voluntary aided" schools on the same basis as Church of England, Roman Catholic and Jewish schools. The government proposed changing the capital funding arrangements to make it easier to establish new schools of this type. This became a highly controversial proposal prompting fears of increased racial segregation and the teaching of contentious religious doctrines such as creationism (Branigan, 2002). While stressing the need for faith-based schools to be "inclusive" (DfES, 2001), the government removed this feature of the diversity policy from relevant official documents (for example DfES, 2002a).

Given the salience of the specialist school model in current policy it is worth reviewing some relevant research. West *et al* (2000) undertook a survey of existing specialist schools funded by the government. By far the most common reason cited for seeking specialist school status (by 51% of the headteachers responding) was the additional money it would bring from sponsors and the government. More than half the heads (53%) said that the specialism chosen for the bid was not the school's strongest teaching area. These two responses might suggest a predominantly tactical approach to the opportunity of specialist school status rather than a strategy born out of educational conviction. In terms of the requirement to benefit other schools, work with feeder primary schools was the most common form of collaboration (as would be

expected in a competitive environment). With respect to other secondary schools, links tended to be with more distant schools such as other specialist schools, those with common sponsors or schools in other countries. In a parallel government-funded study based on case studies of 12 specialist schools, Yeomans *et al* (2000) reported that across all their schools the weakest links were with neighbouring secondary schools. An evaluation by Ofsted (2001) concluded that specialist schools were weak in sharing resources and expertise with local schools and the wider community. This raises policy implications which will be discussed later.

The West *et al* research indicated that specialist schools' GCSE performances have improved more than those of other schools, and a number of other benefits were reported by those involved with the schools. In addition, studies by Jesson (2001) for the Technology Colleges Trust (which is now called the Specialist Schools Trust and exists to develop specialist schooling) using value added methodology indicated that schools specialising in technology and languages added more "value" in terms of helping pupils make progress towards GCSE than did non-specialist schools. Those specialising in arts or sport did less well: they produced value added GCSE scores almost identical with those of non-specialist schools. These findings clearly strengthened the government's confidence in pressing ahead with extending the programme. However, as both reports acknowledge, there could be a variety of reasons for the superior performance of some of these schools. The bidding process may identify improving schools that would have made these improvements in any case, and the additional resources which inclusion in the programme brings are very likely to have a positive influence on performance. Further, such studies are of limited value as a guide to national policy unless they cover not just these schools' own performances but also how the schools have affected the performances of other schools in their localities. The Jesson research has also been heavily criticised on technical grounds by a respected expert in school performance analysis who maintained that this purported evidence for the success of specialist schools "does not stand up to close examination" (Goldstein, 2002).

Nevertheless, Jesson has undertaken the study annually since 2000 (see for example Jesson, 2003) and it is usually the only one referred to in government statements and in press coverage. The Commons Education and Skills Committee criticised the government for relying on too narrow a range of evidence in this area (House of Commons Education and Skills Committee, 2003).

Further research using more sophisticated value-added methodology (Schagen *et al,* 2002) indicated that specialist schools produced only a slight peformance advantage over non-specialists and this advantage was attributable entirely to two of the four existing forms of specialism, technology and languages. This study also provided some tentative evidence that specialist schools might be succeeding at the expense of neighbouring non-specialist schools. It also reported that LEAs with a high proportion of specialist schools (20% or over) did not perform as well as those with a low proportion. "There was thus no evidence to support the suggestion that an increase in the number of specialist schools would yield improvements in overall performance results" (*ibid,* p 45). The finding that (for whatever reason) specialist schools performed only slightly better than non-specialists was supported by a government statistical study. It observed that "Differences in average progress were small compared to the spread of outcomes for pupils with similar prior attainment" (National Statistics, 2002, p 33). A similar conclusion was reached by a study from the National Audit Office (2003).

The Schagen *et al* (2002) study was also one of the very few to examine the performance of faith-based schools. Church of England schools were found overall to perform marginally better, but Roman Catholic schools no better or worse, than non-religious schools. (However the very small number of Jewish schools had significantly better results than either Christian or non-religious schools). The authors concluded that they had not found any clear evidence to support the view that, if these schools created a specially supportive and well-ordered environment, it provided a climate that led to high achievement.

3. *Diversity and choice: a new direction in schooling, or a buttressing of the old?*

One of the government's key principles in 1997, as set out in its White Paper *Excellence in Schools,* was "The focus will be on standards, not structures" (DfEE, 1997, p 5). By 2004 it appears they have discovered the attractions of significant structural change. A major question is whether their present policy stance in the area of choice and diversity turns out to be a radical and visionary approach or a reinforcement of old and deep-rooted divisions. The government has sought to combine a major extension in diversity with an equivalent growth in collaborative practice between schools, even though the central characteristics of, and incentives relating to, the competitive system are still in place. In addition, there is a strongly articulated objective of enhancing equality of opportunity and also a strong focus on reducing the "achievement gap" (DfES, 2001). It will be interesting to see whether diversity, collaboration and equality can all be significantly enhanced or whether the inevitable tensions between these distinct objectives will result in one or two of them becoming dominant. The research on specialist schools discussed earlier indicates that competition and partnership can make uneasy bedfellows. Numerous initiatives emphasising collaboration are underway (Glatter, 2004, in press) and several of them are being evaluated.

Will the new diversity be built on a competitive or a genuinely pluralistic model? As the 1994 OECD report stated: "Unlike some other nationalities, the English are used to the concept that routes to academic success may lie in centres of academic excellence rather than comprehensive neighbourhood schools" (OECD, 1994, p 64) and

that this familiarity derived from both the "public" and the grammar school traditions. Like the City Technology Colleges (CTCs) and grant-maintained (GM) schools before them, specialist schools experienced a significant increase in their popularity following designation, and the majority of headteachers in the West *et al* study (2000) attributed this, at least in part, to their new status.

The policy for specialist and other new types of school was originally presented as "modernising" or "overhauling" the comprehensive system. However, its many critics, conscious of the specific social and cultural context of English secondary education, regard it as signifying the death of that system and its replacement by a two-tier structure of "winning" and "losing" schools and communities. More recently reference has been made (for example in Tony Blair's speech to the 2002 Labour Party conference) to a "post-comprehensive era" but retaining the comprehensive principle of equality of opportunity.

The prospects for achieving a pluralistic rather than an hierarchic/competitive form of diversity seem to depend on at least two key factors. First, in terms of supply, the models so far developed are relatively limited in number and fall far short of the possible range (see the typology of school diversity proposed in Glatter *et al,* 1997, p 8). The policy is heavily dependent on the specialist school model (curricular diversity in terms of the typology) and this dependence has been accentuated by the recent government reticence over faith schools. For example the new "Academies"—publicly-funded independent schools sponsored by private and voluntary bodies and established in areas of disadvantage—are also required to have curricular specialisation. A more creative approach to developing contrasting types of school would be needed, and this would imply a greater willingness to relax central controls particularly in the area of performance regulation.

With regard to demand, there is a critical issue concerning the relationship between diversity and choice. The two terms have now been linked in policy discourse for more than a decade, since the Conservative government's 1992 White Paper, *Choice and Diversity: a new framework for schools* (DfE, 1992): the specialist schools policy has been explicitly presented in terms of enhancing choice (Blair, 2002). However the precise connection between them is very little understood and despite the significant quantity of research on choice and the quasi-market little attention has been given to this particular topic. The limited empirical evidence available suggests that, apart from preferences among relatively small proportions of parents for specific forms of religious education or for single-sex schooling there is no widespread demand for school diversity (see for example Woods *et al,* 1998). Parents generally appear to be simply looking for a school which will deliver the "standard product" well, whether or not it carries a "badge" of distinctiveness. Of course this could change were a range of more distinct school types to become available, but Walford's judgement of some years ago that the (then) government's diversity policy ". . .has been largely generated by the government itself, and has not been the result of pressure from parents" (Walford, 1996, p 145) still holds true.

A pluralistic approach to diversity would require "a relatively even spread of choices" (OECD, 1994, p 42) so as to avoid the situation where some schools widely seen as the "best" are heavily over-subscribed and there is a "concentration of the most disadvantaged pupils in the least popular schools" (DfEE, 2001, p 87). Such a spread of choices would be more likely to happen "if parents have diverse 'frames of reference' placing different values on aspects of educational attainments" (Adnett and Davies, 2002, p 202). Historical and cultural factors militate against such a development in the English context (Edwards and Whitty, 1997).

An important set of issues centre on availability and illustrate the intimate connection between supply and demand. A striking small-scale research conducted in the early 1990s in a single medium-sized English town demonstrated the logistical difficulties involved in increasing diversity (Brain and Klein, 1994). Parents were surveyed about their preferences among the more restricted range of school types available at that time, principally single sex/co-educational and church-linked/non-denominational. The authors calculated that almost twice as many secondary schools would need to be provided in the town in order to meet all the parents' preferences. They also pointed out that if the choice menu had been extended to cover different curricular specialisms and a wider range of faith-based options (as are now being offered) the logistical problem would have been considerably exacerbated.

Parental perceptions of availability are also a significant factor. The PASCI study conducted large-scale parental surveys in three contrasting areas of England. In a semi-rural area, only around one in four parents thought they had a realistic choice between three or more schools: the figure went up to just over half in a medium-sized town. Even in a heavily urbanised area a substantial proportion of parents—varying between a third and a quarter across the three years that the survey was conducted—considered that their realistic choice was limited to one or two schools (Woods *et al,* 1998).

This raises the possibility that increased diversity may reduce rather than enhance parents' perception of the extent of choice open to them. For example, in the case of specialist schools it is an open question whether a choice between a small number of schools emphasising particular subject specialisms will be perceived as a more or a less attractive menu of options than was available previously under a more generalist system. For some parents and pupils, where the latter's specific talents and strengths are already clearly evident by the age of 10, or who are attracted not so much by the particular subject specialism as by the sense of "special-ness" it confers, the offer may be welcome (assuming that they can gain admission). For others the particular mix of specialisms available may be perceived as unappealing or may provide an additional source of anxiety in appearing to require an early judgement about a child's aptitudes.

The next phase of research should examine such issues by focusing directly on the relationship between choice and diversity. This discussion also indicates that neither choice nor diversity is an end in itself. They are both means intended to contribute to wider goals, such as enhancing parent and pupil satisfaction over school allocations and achieving a good fit between the school allocated, the child's educational and social needs and the family's preferences in an equitable manner. Whether and how policy and practice over school admissions contributes to such goals has rarely been examined and requires close attention.

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Memorandum by the Democratic Health Network (CVP 03)

About the DHN

The Democratic Health Network (DHN) was set up by the Local Government Information Unit (LGIU) to provide policy advice, information, research and the exchange of good practice on the developing health agenda for local government. The DHN has 120 members, the majority being local authorities, but also including over 40 other organisations including NHS trusts, primary care trusts, voluntary groups and trade unions. The DHN is committed to working with local authorities and their partners in the public sector, the community and voluntary sector to improve partnership working, increase democratic accountability within the NHS and reverse the trend of growing health inequalities.

Introduction

We welcome the Committee's inquiry as we believe there is considerable confusion arising from competing interpretations of choice, voice and related concepts in the context of public services. The inquiry provides an opportunity to clarify underlying assumptions and consider how the concepts of choice and voice might apply to different aspects of public services. As our name suggests, we are particularly interested in this issue in relation to health services, but we will also draw on examples from personal social services, as we believe that good quality health and social services imply a holistic approach to service users that requires health and social services (as well as other aspects of public services) to operate as a "whole system".

Some Distinctions

In its helpful issues and questions paper, the Committee quotes from speeches of the Prime Minister and other Government Ministers, in which a range of assumptions about choice are operating. In particular, it is not always clear whether choice is viewed simply as an instrumental good, for example, as a mechanism in a market model for driving up quality; or whether the expression of choice is also seen as a good in itself, for example, as a determinant or function of individuals' identity and autonomy.

These distinctions matter not only in themselves, but because they can lead to further assumptions that drive policy in different directions. For example, the conception of choice as a market mechanism leads to an assumption that a diversity of competing service providers should be a fundamental policy objective. In this model, diversity on the supply side offers choice on the demand side. Service users act as commercial consumers would and choose the best providers; the worst go to the wall. Quality is driven up. The impact of this model on policy can be seen in government initiatives to involve private sector health providers in the provision of NHS care.

On the other hand, if the importance of choice is seen in relation to personal autonomy, individual involvement in the design of a particular service and the way in which it is delivered to the service user will matter more than the ability to express preferences between previously-designed services in which the user has not been engaged. The policy emphasis in the latter case may therefore be more on the "voice" aspects of choice. In health, the creation of the Commission for Patient and Public Involvement in Health, patients' forums, elected governors for foundation trusts and the "expert patients" programme may be seen as reflecting this understanding of the importance of choice as voice.

Fairness and Choice

Both the market and the individual autonomy models of choice, when applied to public services, can throw up issues of equity. The market model is based on an assumption of maximally informed individual consumers shopping around to satisfy their own preferences without regard for the impact of their choices on others. The autonomy model can similarly seem to assume that each person can unproblematically assert their identity through their free choices, unconstrained by context or impact. However, the context within which choices are offered and made and the knock-on effects of individuals' choices do have implications for equity, an issue which has a much greater priority in the provision of public services than in the private sector. Examples where issues of equity arise can be clearly seen in the health and social care arena.

For example, everyone can agree that it is desirable for an older person in hospital to have a choice of where they receive intermediate care on being discharged. But there is not infinite capacity for immediate provision of the chosen residential or home care. This means that waiting for the intermediate care of choice to become available can leave the older person inappropriately being cared for in hospital in a bed for which someone else is waiting. This constrains the options of another group of people—those waiting for hospital treatment. Such tensions between the interests of different groups of people can lead to creative solutions, such as the new forms of extra care accommodation that are being developed jointly between the NHS, local authorities and other partners. But such tensions can also mean that individual choices must, or indeed should, be constrained in the interests of the more effective operating of the whole system and of fairness or equity.

It is worth noting that, in this particular example, changes are not being driven by the expression of consumer choice, as the market model would have it. Rather, national priorities relating to waiting lists, the appropriateness of hospital stays and the need for smoother transitions between health and social care have resulted both in legislation and in local initiatives. These are likely to mean that health and social care systems locally are providing more appropriate care, in the sense that more older people are helped to live independently in their own homes, which is precisely what the vast majority of them want. Frontline service staff emphasise that preventive measures, such as falls prevention services, that contribute to the goal of independent living can only be introduced with the understanding and active participation of service users and carers. Some of this happens at an individual level and some of it through initiatives like older people's partnership boards where services are discussed and redesigned in consultation with those who will use them, their carers and representatives. Many decisions about local service reconfigurations are made ultimately by elected councillors on the basis of such consultations. It is the "voice" aspect of choice that is influential in this kind of service change.

The above example shows that offering a choice to one group of people can sometimes impact unfairly on another group. The Government sometimes seems to be guilty of arguing for the compatibility of individual preference with equity by simple assertion. For example, the Department of Health's consultation exercise on choice in health services was called, Choice, responsiveness and equity: fair for all, personal to you. At the consultation events organised by the Department of Health, there was little discussion of the responsiveness and equity aspects of the exercise. Instead, participants were asked to say, in relation to six

NHS services (eg maternity services, cancer services) what choices they personally would want to have. The structure of the events made it difficult to consider potential trade-offs between the exercise of choice in one area and consequent constraints in another that would inevitably follow in a context of scarce resources.

Collective Choice

There is no easy mechanistic way of determining to what extent choices should be made available or be constrained. Should an older person have no more than three options for residential care, for example? Is this a more fundamental choice than the choice of which hospital to attend for an operation? The difficulty in answering such questions makes it all the more important to be honest about the trade-offs and have an open debate that reflects society's priorities about which choices are really fundamental, which a function of basic human rights, when choices for one group constrain choices for another and so on.

One way in which, in a democratic society, we make difficult choices is through elected representatives who are expected to balance the competing interests of different groups. Choices about how a society works cannot always be made at the level of individuals. The arena of public health is one in which collective choices have increasingly been seen as appropriate and sometimes these collective choices have restricted individual choices for some people. For example, a decision about whether to have a fluoridated water supply cannot be made by each individual since the water supply is shared. There is currently a debate about whether smoking should be banned in public places to reduce the effects of passive smoking on those who frequent and work in such settings. Decisions on such issues must be a matter of collective choice, if there is to be a choice at all. And the democratic process much surely be the way to make such collective choices, whether at national or local level.

Should collective choices that affect public services, including health, be made at national or local level? As an organisation that supports local authorities we believe that the principle of subsidiarity should apply—decisions should be made at the most local level possible. This brings collective decisions as close as they can be to individual decisions and should result in services coming as close as they can to the "personalised" ideal which the Government is currently promoting. This does not mean, of course, that no decisions should be made at national level. For example, the Government is, rightly in our view, introducing national standards across the NHS through National Service Frameworks for different medical conditions and groups of people (eg for older people, people with mental health problems, the treatment of cancer, coronary heart disease, diabetes). There is now a general acceptance, with which we agree, that you should be able to expect a certain standard of care wherever you live in the country. The introduction of such national standards implicitly recognises necessary constraints both on the scope of local collective choice and on individual choice.

Another area in which only a national collective choice will do the job is, arguably, that relating to immunisation. The debate about the triple MMR vaccine is throwing this issue into high relief. The Government has so far stuck to its position that the triple vaccine provides the best immunity for the population as a whole with almost no risk to individuals. But what now appears to be happening is that some parents (early evidence suggests a disproportionate number of middle class parents) are refusing to have their children vaccinated, and, in effect, relying on the "herd immunity" provided by those who do. If increasing numbers of children fail to be vaccinated, this herd immunity will disappear. Clearly, population immunity cannot be created by allowing each individual to choose whether to be immunised or not. (The MMR debate is complicated by the fact that objections centre primarily on the triple vaccine, rather than on the idea of any form of vaccination against measles, mumps and rubella, but the general point about population immunity still applies.) Issues such as this may be seen as exemplifying a conflict between personal choice and collective choice, or as a clash of incompatible rights. But from either perspective, it is clear that the benefits and disadvantages of personal choice in public services must sometimes be weighed against the collective national interest.

But other choices about services, such as those that recognise the particular character of a local population can and should be made at a local level. For example, in the London Borough of Lambeth, where a significant proportion of the population are of African Caribbean origin and therefore at greater risk of sickle cell anaemia, the local health service has prioritised the development and promotion of screening services for this condition. Such examples suggest that local government, which is run by democratically elected representatives, should have a greater role in local collective choices about health priorities.

We believe that considerations about collective choices are pertinent to the debate about personal choice in public services. The examples above show that some choices can only be made collectively and also, we believe, that some choices should only be made collectively. One effect of this position on individual choice is that individuals should not be able to opt out of public services altogether, as appears to be the case with some "gated communities" in the USA.

Real Informed Choices

The exercise of genuine choice depends on being informed about the relative advantages and disadvantages of alternatives. As the Committee's paper has rightly pointed out, inequity in access to information can lead to inequity in choices available. We agree with the concern recently expressed by the Chair of the British Medical Association, James Johnson when he said that choice in the NHS

> "has to be meaningful, well-informed, and available to all our patients. If information about healthcare is only available to white middle-class English-speakers, we will disadvantage the patients we most need to empower[2]."

Mr Johnson was referring to the planned system of electronic booking of operation which would give patients an opportunity to choose between several hospitals after looking at waiting time and performance tables showing the success rates of hospital departments and individual surgeons. This example shows how inappropriate the conception of choice as a market mechanism is when applied to health. On the market model, patients would choose the doctors with the greatest success rates, whose "business" would then increase. The others would either increase their success rates or go out of business.

There are several reasons why this model will not and should not apply in the NHS. We cannot afford to close down hospitals or strike off clinicians who are performing less than optimally, because of pressure of numbers. A public health service for a whole population or, indeed, personal social services, cannot simply respond as in a commercial market, to the expression of consumer preference. If, as a result of a high success rate (however that may be judged), surgeon X has a long waiting list, the only way to deal with this is to allocate more treatment to surgeon Y who has a shorter waiting list because of s/he has a worse success rate. The choice will therefore be between a long wait and treatment by a "better" hospital or clinician.

Of course this is a crude picture because, like school league tables, unless they are very detailed and sophisticated, hospital league tables will not be indicators of quality at all. For example, they may not account for factors beyond the control of hospitals and individual clinicians, such as the health profile of the population to which they are currently providing services. Nor will simple league tables be able to show "value added", for example where someone with very complex health needs is operated on. Simple league tables where comparisons may easily be understood will need a lot of background information to be correctly interpreted. Complex and detailed league tables will be more difficult to understand. In either case, fears of inequity are likely to be well founded.

If all sections of the population are to be in a position to make well informed choices between health treatment options, NHS information gathering and dissemination systems will need to be very much more sophisticated than they currently are, and will also need to be very much more personalised and, therefore, labour intensive. This will be expensive. It may well be a price worth paying, but the cost to the NHS, when it is not clear whether or which people want such choices, may be too much.

Choice and Voice

It may be that some hard decisions will have to be made about which choices matter most to the quality of people's lives. To take an example from social services, the option of "direct payments" to individuals such as disabled people to plan and organise their own care, rather than receive a service which they do not control, is proving immensely popular and liberating to the small number of people who have been able to take the direct payments option so far. One of the aspects which disabled people themselves say is most important to the success of the direct payments scheme and which will need to be considered when the scheme is extended, as is intended, much more widely to additional groups, is the support they receive in using their direct payments (for example in recruiting care assistants and in fulfilling their role as employers).

We had concerns about the direct payments system when it was introduced. We feared that it would reduce capacity in the social care system to provide care for those who still wanted or needed this option. We were also concerned that the payments might not keep up with the costs of care required and that there would not be sufficient support for those making use of direct payments. These concerns remain and while it is clear that abandoning the scheme would cause outrage among those now using it, we believe that the lesson to be learned is not that everyone who needs a public service should be given a sum of money and told to get on and organise it for themselves. Rather, if disabled people had had more say in the design of services and in how they were delivered, they would not have been so dissatisfied in the first place. In fact, in some areas voluntary sector organisations of disabled people have been contracted to provide a support service to those receiving direct payments. This means not that a service has ceased to exist, but that a completely new model of service is being developed which allows service users greater respect, acknowledges the diversity of their needs and wishes and offers them greater autonomy.

It is not clear that the kind of choices the Government is talking about are a priority for ordinary users of public services. The Government's consultation exercise about choice in the NHS, Choice, Responsiveness and Equity: fair for all, personal to you, elicited many responses suggested that what most mattered to people was, not so much a choice between different services, or the option of travelling far from home for a quicker treatment, as having a good quality, convenient, local service in which issues such as

[2] Speech to annual meeting of junior doctors, Edinburgh, April 2004.

being treated with dignity and respect, having the opportunity to understand and talk about their medical condition and, when things went wrong, knowing that the same mistakes would not happen to other people in future. We understand that research currently being undertaken by the National Consumer Council for the Department of Health will confirm these priorities.

Should Government Ensure that Choices in Health and Social Care (and Other Public Services) are Based on Evidence of What Works or on What People Want?

This question raised the issue of the role of experts in public services. Specifically in health, how do we offer choices that will affect the treatments that people receive while at the same time acknowledging scientific evidence and the expertise of health and social care professionals? The Government has rightly insisted on evidence-based practice which would rule out offering some "alternative" treatments on the NHS which some, perhaps many people would like to have, unless or until these treatments have been shown to be effective by accepted scientific methods. This does not mean that there should be no choices available to patients about the type of treatment available to them. In many cases, there are alternatives, each of which have risks and benefits which patients are capable of assessing and choosing among, if they are given clear information and support. An example of this process would be assisting pregnant women to choose birth methods for their children.

Sometimes, the system restricts health professionals' own desire to respect patients' wishes and autonomous choices. An example is in the treatment of people with mental health problems—an area in which people's sense of their own worth and autonomy is most vulnerable. Primary care drugs budgets are not cash limited. But psychological treatments are. This means that there is a disincentive in the system to offer the latter. A system for offsetting savings on one type of treatment against the other could incentivise flexibility between treatments and offer patients a greater say their own treatment.

Conclusion

We do not believe that choice in public services, and especially in health and social care services, should primarily be seen as a mechanism for improving quality on a crude market model of competition between service providers. (We doubt that the market model is a correct one even for commercial markets, but that is another story.) We believe that the kind of contestability that might contribute to increased quality can be provided on a different model (this is elaborated in more detail in the submission to the Committee from our parent organisation, the Local Government Information Unit). A diversity of providers is neither necessary nor sufficient to offer the sort of choice that would make most difference to the quality of services and to the lives of service users.

Instead, the emphasis in considerations of choice in public services should be on those factors that can be subsumed under the term, "voice". Choice in this sense should be seen as a good in itself: not only personal choice which enables people to affirm their autonomy and assert their individuality; but also collective choice which enables people to see themselves as part of a wider whole and to contribute to the well-being of others, as well as mediating between different groups in the interests of equity.

Our final point is that a society in which all individuals, groups and their representatives had equal opportunities to make informed, deliberated, evidence-based choices about public services and how they are used would need to acknowledge the time and effort required for this. One of the reasons that more choices for individuals can bring inequity, as we have seen in the case of "parental choice" in relation to schools, is the inequity in the resources (of time, information, education, personal contacts, working conditions etc) available to different people. If this is not recognised, increasing individual choices will bring increasing inequality. Conversely, support for individuals in making real choices about public services that affect them in many aspects of their lives should be acknowledged in working hours, information technology available, personal support from service providers and so on. Equally, those public servants and elected representatives whose job it is to help people make informed choices and to make fair and informed collective choices on their behalf need much greater recognition of the complexity of doing this in a consultative and collaborative way. This is why the issue of choice in public services cannot be divorced from the support we give to our democratic processes, both nationally and locally.

Democratic Health Network

April 2004

Memorandum by the National Consumer Council (CVP 04)

The National Consumer Council (NCC) is an independent consumer expert, championing the consumer interest to bring about change for the benefit of all consumers. We do this by working with people and organisations that can make change happen—governments, regulators, business and people and organisations who speak on behalf of consumers.

We are independent of government and all other interests. We conduct rigorous research and policy analysis and draw on the experiences of consumers and other consumer organisations. We have linked organisations in England, Scotland and Wales, and a close relationship with colleagues in Northern Ireland. And we work with consumer organisations in Europe and worldwide to influence governments and institutions.

We are a non-departmental body, limited by guarantee, and funded mostly by the Department of Trade and Industry.

This memorandum responds to a request from the Clerk of the Committee for a written submission in connection with the Committee's Inquiry into Choice and Voice in Public Services.

Introduction

The NCC has a long-standing commitment to ensure that people have a voice in the provision of the services and products that affect the quality and experience of their lives. But today's consumers are highly sceptical about involvement processes, believing that even when they are consulted it is often cosmetic. To promote the necessary shift in attitude from public service providers and other bodies to make consumer involvement an essential part of their everyday operations, the NCC published the report *Involving consumers: everyone benefits* (September 2002—link provided at end of document).

This report was the result of a major project that examined the benefits of, and investigated the barriers to, consumer involvement. The report showed that consumer voice is an essential ingredient of good policy-making. The NCC recommended that there should be:

- A central strategy for consumer involvement that makes it a priority as part of public service reform.
- Greater co-operation between public bodies, and joint working arrangements where appropriate.
- Practical support to make it work that includes training, tools and techniques and sharing of good practice.

The NCC is also concerned that the much talked-about consumer apathy is a myth. A survey conducted for the NCC by MORI showed that, despite consumer scepticism, people are keen to be active, with nearly 70% of those surveyed reporting that they had been active in some way in the past. Activities ranged from contacting their local councillor or MP; going to a public meeting; getting in touch with an advice agency; joining a local group (such as parent/teacher association or passenger group); and organising a petition.

When consumer involvement is done well it can help service providers design and deliver services that genuinely meet people's needs, boost standards, identify problem areas and provide value for money.

Definition of Choice

In 2003 the NCC held several focus groups and commissioned some research by MORI, on behalf of the NHS which started looking at the issues surrounding choice and tried to examine a possible definition for the word. The findings showed that in general participants felt that they did not have any choice at present. They were concerned that all doctors' and dentists' books are filled and that there is a restriction that confines them to treating only people who live within a three-mile radius of their surgery.

Respondents found it difficult to come to terms with choice, not really understanding how it would work. Overall, respondents felt that having a choice would be a good thing, although there were some contradictory arguments, as some people felt that GPs were the experts and should be able to tell you what to do.

While most people felt that they didn't currently have any choice, it should be noted that most people also felt that they didn't want choice. There was a widespread feeling that people weren't used to exercising choice in healthcare, and some felt that choice was an artificial concept in healthcare. For example, choice of treatments came low down people's priorities, as many participants felt that the expert opinion of doctors should not be challenged and that there shouldn't be any "bad" doctors.

For the less affluent—most participants saw that the challenges to the NHS overall were to improve services in general, rather than implement "choice". Choice was a secondary concern when placed alongside being treated well, quickly, efficiently and effectively. However, some did feel that choice would mean that patients could leave poorly performing hospitals for better hospitals and this would force these failing hospitals to address these problems.

Some perceived barriers to choice were evident in the responses of this focus group. For example, it was apparent that patients were unaware that they have a choice of treatment or hospital, as doctors do not inform them. It was also mentioned that there often wasn't time to discuss treatment options in a doctor's appointment.

Overall, respondents felt that having a choice would be a good thing in theory, although doubts were expressed as to the practical application of choice. Group participants felt that they did not have any choice at present in NHS services. They found it difficult to relate the concept of "choice" to healthcare—as one

participant noted, people in Britain are not used to exercising choice in this arena of their lives. Another felt that choice could only ever be based upon past experience, and that most people do not have sufficient experience of the NHS to exert that choice.

Independent Policy Commission

In December 2002, the National Consumer Council (NCC) set up an independent Policy Commission on Public Services to examine the current delivery of services to consumers and to try to answer three overarching questions:

— What is the relationship between choice and equity?

— What is the relationship between consumers and citizens?

— Are consumer expectations of public service changing?

From the beginning it was understood that the Commission would be properly independent of the NCC and, within the broad terms of its remit, free to undertake a wide-ranging investigation of the current state of public services from the consumer viewpoint. This the Commission did, using as reference four specific public service sectors: primary health care; personal social services; secondary education; and physical urban regeneration.

The Commission undertook its work through a series of workshops and multi-disciplinary, cross-stakeholder seminars with thinkers, regulators, educators, providers, consumers and professionals across the four service sectors. Over 180 individuals and organisations were asked to contribute to the work of the Commission. The Commission's tentative conclusions were further tested through direct consumer research. The report, making public services personal: a new compact for public services has just been published (link attached at end).

Choice and Voice

The findings of the Commission suggest that public service reform is beginning to deliver but progress is patchy. The report concludes that services must now adapt to social and cultural change—shifting family structures, growing individualism and greater diversity of race and culture—or public confidence may ebb away from key sectors such as health and education.

The Policy Commission examined how both "choice" and "voice" should be extended to rebalance services towards the interests of users. In pursuit of greater responsiveness, but within public service values, it argues that there should be more experimentation with funding streams that follow individual choice. The report also argues that, while choice can be an important driver to improve quality and make services more responsive, voice also plays a crucial role in making sure that services really meet people's needs. The Policy Commission recommends that, as well as improved public involvement and consultation, government should use its purchasing power to embed stakeholder engagement throughout the service delivery chain.

A strong message to emerge from the Commission's discussions with public service users was that people want public services to be more personal. Users prize the relationship they have with professionals whose treatment of them colours their experience.

However, while the report holds that choice should be extended, there are distinctions about consumer choice that need to be made. For example, it is necessary to distinguish between different types of choice (including choice over different types of service or over different providers, and economic and non-economic choices) and the limits on choice, for example, where individual choice conflicts with the public interest.

In addition to choice, the expression of voice is critical to empowering users. This covers a spectrum from complaint and redress to full stakeholder dialogue. Voice is a critical tool in enabling managers, providers, commissioners, procurers and regulators to balance the conflicts that arise from the allocation of limited resources, and from competing interests. This voice must be heard at the point at which services are commissioned, regulated, inspected and monitored and not just at the point of supply.

Choice

The report puts forward both choice and voice as effective tools for ensuring responsiveness in public services. However, neither can be thought of as a panacea and both have strengths and weaknesses. It is not always the case that individuals are well enough informed in the exercising of choice. We should, therefore, deploy choice and voice to best effect where they contribute to specific outcomes, and also recognise where they do not work, and know how to proceed when they conflict with the public interest.

In some cases, the extension of individual choice conflicts with the public interest—for example, in the case of the MMR jab. It is the job of government to ensure the extension of individual choice does not adversely affect others. The need for explicit public values that guide arbitration between the public and consumer interests is paramount. In addition, the report covers some important considerations in recognising the limits to choice:

— Choice can compound inequalities as take-up of choice varies across the social divide.

— Choice can compound inequalities when disadvantages like information poverty are not addressed. Advice, information and advocacy may be needed by vulnerable consumers to avoid making existing disadvantage even worse.

— Greater clarity is needed on outcomes when introducing choice. For example, an outcome could be to rebalance disadvantage or discourage exit from public services by the more affluent.

— A lack of clarity of the technical indicators that warn that choice is not effective. This occurs, for example, when service providers cannot accommodate greater consumer power, when there is no flexibility regarding resources or when economic means (such as vouchers) are not sufficient to compensate for different needs.

Voice

The report considers the democratisation of public services across a spectrum, which includes public involvement and consultation, stakeholding and public involvement in new forms of governance. The Commission holds that there is a disconnection between people and public services when the public is limited to expressing its voice by the rather abstract rights afforded through citizenship. Users need to be able to make choices at an individual level, to contribute to the negotiation between different groups of interest at a stakeholder level, and voice opinion as part of the wider collective public interest.

While the report calls for a greater extension of voice for users at an individual and stakeholder level, it recognises the following constraints:

— The extension of voice is dictated and managed by providers and therefore does not offer the same bottom-up empowerment that choice affords.

— Consultation processes can conflict with efficiency if the desired ends are not clear or if they are unrealistic.

— Stakeholder processes are subject to capture by unrepresentative groups if not carefully managed.

— Involvement and consultation that doesn't affect outcomes can increase cynicism and contribute to "consultation fatigue".

— User involvement in governance needs to be matched by a mature understanding of risk sharing if individuals are to take on greater responsibility for decisions that directly affect others.

— Processes involving the public need to develop in sophistication and appropriate use if they are to build public confidence. Experience in this remains limited, particularly in the area of governance.

Customer Satisfaction

In February 2004 NCC wrote to selected Government Departments regarding their Public Service Agreements (PSAs) and in view of the Comprehensive Spending Review (CSR) 2004.

Whilst we welcome the current Public Service Agreements (PSA) we feel that the government needs to ensure that consumers are at the heart of policy. The NCC is concerned that only seven out of around 130 PSAs focus explicitly on customer satisfaction. There are a number more which focus implicitly on customer satisfaction. However the NCC would like to see more quantifiable consumer-focused measures at the heart of the next round of PSAs, through:

(a) Explicit inclusion of improved satisfaction or experience of your public service users in the formulation of PSAs and/or;

(b) The explicit application of customer satisfaction measures as a way of assessing PSAs. We understand that PSA formulation is not changing in this CSR 2004 but we do want to highlight the implicit impact on customer experiences.

The NCC would like to see the Government's commitment reflected in a further range of realistic targets.

NCC will be considering the Policy Commission's findings over the coming months and will be more than happy to discuss these issues further with the Committee. For your information please find enclosed Chapter Three of the report which relates specifically to "choice and voice".

I enclose below the link to the full Policy Commission report:

http://www.ncc.org.uk/pubs/pdf/policy_commission.pdf

The link below is to the report *Involving consumers: everyone benefits*

http://www.ncc.org.uk/pubs/pdf/involving_consumers.pdf

Memorandum by the Local Government Information Unit (CVP 06)

The Local Government Information Unit is an independent policy and research organisation which provides an information, advice, training and lobbying service to its local authority and trade union members. The LGIU celebrates the strengths of local democracy and advances the case for greater powers, discretions and financial freedoms for local government.

Choice is a naturally appealing concept and the idea of choice in public service reform has already expanded to encompass several distinct meanings and goals. In this memorandum LGIU want to highlight some of the issues raised by expanding choice in public service.

By highlighting the variety of ways in which choice can be advanced we want to draw to the Committee's attention to the greatest threat facing both the choice agenda and public service reform: that central government will try to prescribe conclusions from the centre, rather than letting them grow organically as local public services respond to the varied demands of local people.

We report our comments under six categories:

1. Basic Ideas in Choice
2. Compulsion
3. Collective Choice
4. Variety vs Quality
5. Does Choice Demand Contest?
6. Optimising Contestability

Basic Ideas in Choice

For individuals choice is an important contribution to giving people control over their own lives.

Choice in public service should eliminate (or significantly reduce) the effort in receiving a service (for which one is eligible) personalised to one's individual requirements.

Many public services are imposed, not chosen. Arrest, being put on the "at risk" register, or receiving a parking ticket are never choices. Even so, these services should be personalised and can give people more control over their own lives.

Collective choice is needed for "public goods". Services and things that cannot be divided up, like pleasant streets or parks, cannot be designed on the basis of individual choice. Collective choice means that either bicycles are allowed in the park, or they are not allowed.

Choosing for variety has different implications than choosing for quality. Choosing for variety involves selecting different services, or more commonly different forms and timings of service, to match one's life style. In this type of choice there is no commonly agreed "best" option. Halal diets and paying council tax online at midnight are examples of choice from variety. Choice for quality reflects choices made when there is common agreement which service is best. People with the same income have different spending priorities. One person buys a new car, while another spends the same money on a luxury holiday. In public service this type of choice mechanism breaks down because full costs are not charged to users and services are provided on the basis on need.

All of these forms of choice can—in principle—be delivered without contestability or competitive pressure being applied to public service organisations. Choice only increases contestability when movement of resources is linked to user choices. User choice has the maximum impact on contestability when it triggers instant and automatic movement of cash from one provider organisation to another.

The major concerns about choice spring from the side effects of contestability.

Compulsion

Many public services are regulatory and often have to be imposed on users. If choice is given greater priority in public service reform, it is important that this does not lead to a lack of effort in personalising compulsory services.

While a public service, such as issuing parking tickets may be imposed, components of the service can respond to user choice. Thus parking tickets may have to be paid, but they could be paid in person, or online.

Local government initiatives such as one-stop shops, neighbourhood offices and transactional web sites are early examples of how services can be personalised to user preferences, even when the service itself is not wanted.

Collective Choice

Local government has taken the lead in trying to find ways enhancing choice where "public goods" mean it is impossible for people to have different choices. Dozens of councils have now experimented with area and neighbourhood forums. By devolving resources and decision-making rights they have sought to make it easier for groups of people to reach collective decisions about their local environment.

Variety and Quality

Choosing for variety has very different implications to choosing for quality. Choosing for variety is driven by life styles. In an old people's home, choice of diet reflects culture rather than quality.

Creating a variety of forms of service in this way is easier than ensuring all services meet a common ideal of "best". Local government's championing of equal opportunity and diversity policies has created many years experience in trying to identify and respond to these different user preferences.

Choosing for quality is far more problematic. In this case there is common agreement about what is best. What is best is likely to be the most expensive as well. For private sector goods and services the numbers choosing the "best" service would be reduced by price. Full cost user charges would simply introduce wealth inequalities into the provision of public services. To provide choice for everyone in this case requires either more resources, or innovations by public services that allow them to provide this "best" service at a lower cost. At this point the issue of contestability has to be addressed.

Does Choice Demand Contest?

Contest is not inevitable in any of the cases described above. Local government has made progress in personalising services and giving more choice across the range of its activities and even with compulsory services.

However, it is argued that progress would be swifter and more successful if contestability were combined with choice. Those arguing for the use of contestability suggest it will promote more innovation, delivering more personalisation of services than before. Contestability can be very powerful in driving organisational change. Contestability drives improvement either by triggering innovation within organisations, or by killing off the weakest organisations. For public services the first route may be welcome, the second is not.

Where innovation is triggered by competitive pressure it will occur in one of three ways. Quality can reduce, inputs costs—mainly staff conditions—can be reduced, or genuinely new ways of working can be created. It is the third option that produces better public service without side effects.

If choice demands contest, then public services will need an array of tools to help it manage the side effects of contestability.

Optimising Contestability

Contestability creates issues to be managed.

Information

Information inequalities must be redressed. Public services must provide advisers as gate keepers to user choice in order to ensure all users have an equal ability to make choices they will not later regret.

Capacity

Any system that lacks the resources for the task will fail. There is a more specific resource problem for public sector providers that does not affect the private sector. Public service organisations encounter resource capacity problems when investing to meet pent up user demand. This problem is most acute in capital spending. If public services cannot build new infrastructure to meet the demand that flows from success, then any choice-driven system will eventually replace public organisations with private sector ones. This will happen because successful public sector organisations cannot expand to meet demand, but they can shrink. Private sector organisations can expand. Thus without capital investment powers to meet growing demand, every public sector success is given away, while every loss is permanent.

Government have made some reforms that reduce this problem. The launch of the Prudential Framework on 1 April 2004 will help local government organisations to invest for future demand. Resource accounting in central government provides similar possibilities. However, more must be done to spread both technical skill and awareness of how to use these emerging opportunities.

Flexibility and Risk

The public sector has a similar problem with flexibility and risk. A choice driven model depends on organisations that can experiment and change approaches swiftly as they try to fit in with user choices. Yet the rules within which public services operate reduce freedom of action. The traditional bureaucratic cautions of the past have been intensified by more recent target driven central controls.Unless central government dramatically relaxes the existing control mechanisms, the public sector will be unable to respond to the choice agenda and private sector firms will be the only viable source of innovation.

There is some evidence of government willingness to relax central control. Local Public Service Agreements offer a chance for innovative councils to escape central targets, if they can exceed central government expectations. The recent Treasury report 'Devolving decision making delivering better public services' is another welcome rhetorical step in that direction. However, central government will have to go much further if it is to free public services to respond to user choice.

Contest without Markets

The idea of contest is too frequently drawn back to the economist's idea of market competition. In turn market competition is too often equated to perfect market economics. In fact contest without markets is also possible and can be more desirable.

The perfect markets ideal would end all hope of innovation. Perfect markets clear instantly moving all resources to the most efficient provider. They thus leave no time for organisation to learn how to improve.

Imperfect market competition leaves time for organisations to improve. But that slack in the system can also allow them to choose not to improve. Imperfect markets allow organisations to choose how to respond to competitive pressure. It is the values of the organisation that have most impact on which route it chooses. This is why a public service ethos is necessary in developing a choice agenda.

In fact there is evidence that the impact of contestability depends most on a combination of two forces. The organisation must feel that contest poses a credible challenge to its future. The organisation must value the direction of change that contest is pushing it towards.

This can also occur through forms of non-market contest. Examples of this include inspection regimes that have won legitimacy amongst the inspected, peer challenge, co-operation clusters in schools education and local public service agreements.

Conclusion

Choice for users is a good measure of how responsive public service is being. Even where choice is not appropriate or easy, asking questions about how to provide more choice in public service is worthwhile.

For organisations to expand choice in public service they must become swifter more skilled innovators. We have discussed some of the factors that will affect how much contest can drive innovation. For government policy makers there is one over-arching issue.

By its nature innovation has not yet been thought of. It will come from many different sources and it will meet a myriad of different demands from different public service users. This is too complex to be a top-down process.

Too often central government has sought to design the perfect solution and then impose it on all local services. An innovation driven public service cannot wait for Whitehall to catch up. If contest and user choice are linked, then government must free councils and other local organisations to respond to user demand as it happens. Only an organic and bottom-up model of public service will be able to respond to the demands of contestability.

Memorandum by the NCVO (CVP 07)

1. Introduction

1.1 NCVO is the largest general membership body for charities and voluntary and community organisations in England. NCVO has sister councils in Wales, Scotland and Northern Ireland. Established in 1919, NCVO gives voice to over 3,500 organisations ranging from large "household name" charities to small self help groups involved in all areas of voluntary and social action at the local level. NCVO champions the cause of the voluntary sector. It believes that the voluntary sector enriches society and should be promoted and supported. It works to increase the effectiveness of the sector, to identify unmet needs and to encourage initiatives to meet those needs. It does this by providing a wide range of information, advice and support services and representing the views of the sector to government and policy-makers.

1.2 This submission:

- describes the various roles that voluntary and community organisations play in relation to choice and voice in public services;
- outlines NCVO's expertise in relation to this Inquiry; and
- sets out NCVO's views on the questions posed by the Public Administration Select Committee.

1.3 NCVO welcomes this opportunity to submit written evidence to the Public Administration Select Committee Inquiry into Choice and Voice in Public Services. We would be happy to provide further information by giving oral evidence to the Committee.

2. Role of the Voluntary and Community Sector in Public Service Delivery

2.1 Voluntary and community organisations (VCOs) have always been important in relation to public services. VCOs play a variety of roles in relation to both choice and voice:

- as providers of public services (funded under contract or through grants) VCOs help contribute to the range of services available to the public. They contribute to choice as an alternative provider either for the commissioning public sector agency or for the individual service user;
- through advice, information and advocacy VCOs can assist individuals or communities who wish to make use of choice in public services; and
- as advocate, adviser or lobbyist VCOs can enable the voice of individuals or communities to be taken into account when public services are designed and/or delivered.

2.2 In the last few years the emphasis has been on the role that VCOs can play as a provider of public services. Government has recognised that the sector can play an important role in its agenda to modernise public services and to increase choice. The role of voluntary and community organisations in public service delivery was one of the seven cross cutting themes of the Spending Review 2002. The review considered:

- the extent to which the sector already delivered public services;
- the scope for taking on a greater role;
- the barriers preventing VCOs from delivering public services; and
- made recommendations to enable the sector to play a greater role.

2.3 Voluntary and community organisations are interested in helping to deliver public services where they believe that they can do so in ways which benefit the end user: this is often referred to as the added value of the VCS. A statutory provider may contract with a VCO to deliver services for a variety reasons, including:

- it has specialist knowledge and skills that the public sector lacks—for example drug or alcohol rehabilitation services;
- it can fill a niche in the market that is too small or specialist to be cost effective for the public or private sectors;
- as a specialist in the field across a region or nationally, levels of expertise and the potential for economies of scale are greater than for a local statutory agency;
- the community it is providing the service to has higher levels of trust and confidence in an independent voluntary organisation than they would a statutory agency—this is true for many homeless services;
- it is based in the local community and therefore has a greater knowledge and understanding of local needs and preferences;
- it can develop services in ways which meet the social, cultural or religious preferences of particular groups more effectively than a single statutory provider can;
- it has the capacity to develop new and innovative services more quickly than a statutory agency can; and
- it can help the statutory provider to offer a range of services for customers to choose from.

Size and scope of the voluntary and community sector

2.4 NCVO's 2004 UK Voluntary Sector Almanac shows that in 2001–02 the total income of the UK voluntary sector was £20.8 billion, that the sector had a workforce of 569,000 paid employees and that the sector contributed £7.2 billion to Gross Domestic Product (GDP). The Almanac also shows that 37% of the sector's total income derived from the statutory sector. Increases in statutory income were largely the result of more earned income (ie contracts) not more grants. However the greatest growth in income and the highest levels of statutory income are found in the larger voluntary organisations (those with an annual income in excess of £100,000). Whilst this is a significant part of the sector's income it represents only a tiny proportion of the amount government spends on public service delivery.

3. NCVO's Expertise in Relation to this Inquiry

3.1 The role of the VCS in public service delivery, how that role is understood, and the implications that delivering public services can have for the VCS have been key areas of work for NCVO for many years. Relevant areas of work are summarised below. All of the documents mentioned in this submission can be made available to the Select Committee if required.

Treasury cross cutting review

3.2 NCVO contributed actively to the cross cutting review. Stuart Etherington, NCVO's Chief Executive, was a member of the Treasury Advisory Group. In addition, each of the five working groups that developed recommendations for the final report included NCVO staff and/or trustees.

3.3 We made a detailed submission to the Treasury review which was informed by extensive consultation with our members. In addition, we undertook a separate review of the role of service delivery in rural areas. We submitted a separate paper on rural service delivery to the Treasury.

Implementation of the cross cutting review recommendations

3.4 NCVO has played an active role in taking forward many of the recommendations of the cross cutting review. In particular we have helped develop the proposals for the new *future*builders[3] fund. A member of NCVO's Policy Team was seconded to the Treasury on a part-time basis for six months to help develop proposals in relation to futurebuilders and to undertake consultations with the sector. NCVO now forms part of the consortium which will provide information and advice to voluntary and community organisations that bid for funding from futurebuilders.

3.5 We have been working with others in the sector to promote understanding of the principle of full cost recovery. A key recommendation in the cross cutting review was the recognition by the Treasury that it is entirely legitimate for VCOs to include in contract and grant bids an appropriate proportion of their overhead costs. The Association of Chief Executives of Voluntary Organisations (ACEVO) have developed a template to help VCOs calculate contract and grant bids on a full cost recovery basis.

3.6 We are currently working with the National Audit Office on a study to review the extent to which some of the key recommendations of the cross cutting review have been implemented by government departments.

Local delivery and local government

3.7 The recommendations of the cross cutting review apply primarily to central government. However the majority of VCOs governmental relationships are at the local level, not with national government. NCVO has therefore developed a significant strand of work around the relationship between local government and the VCS. This has included work on best value (including a guide to best value for the VCS and a guide on demonstrating best value when bidding for contracts to deliver local services) and on community leadership and community representation.

Implications of public service delivery

3.8 We have commissioned research based on 12 case studies to help improve our understanding of the impact of public service delivery (and the cross cutting review) on VCOs. We aim to publish the findings of this research during the summer.

3.9 Over the past year we have published three major policy discussion papers which review the implications of public service delivery and working more closely with government for VCOs:

— A little bit of give and take: voluntary sector accountability within cross-sectoral partnerships;

[3] *Future*builders is a capital investment programme of £125 million over three years which is intended to help increase the capacity of voluntary and community sector service delivery organisations.

— Voluntary sector added value; and

— Standing apart, working together: a study of the myths and realities of voluntary and community sector independence.

3.10 Stuart Etherington, NCVO' s Chief Exectuive, is a member of Future Services, a group set up between NCVO, the CBI and the National Consumer Council and facilitated by LLM to review how user perspectives are taken into account in public services. In addition, Ann Blackmore, NCVO's Head of Policy, was a member of the Advisory Group for a recent research report published by the New Local Government Network, Making choices: how can choice improve local public services.

4. NCVO Response to Questions and Issues Raised by the PASC

Defining what choice means in the public sector

4.1 In order to define choice there needs to be clarity as to the purpose of choice and who the choice is for. Choice may be directed at individual services users, at particular communities (which may be geographic, for example a particular neighbourhood, or a group with shared interests or concerns, for example those in residential care) or it may be for the statutory provider to choose from a range of potential contractors.

4.2 Choice should not be seen as a euphemism for competition and the market. Nor should choice be seen as an end in itself. The primary purpose of choice should be to improve the quality of services available to the user. Competition and market mechanisms may play a part. But this will not necessarily be the case: there have, for example, been recent cases of local authority residents making clear their desire to stay as council tenants and not be offered alternative landlords.

4.3 Choice may mean a variety of providers are offered to a service user. But it can also mean a single provider offering a range of choices for the way a particular service will be provided.

4.4 It seems reasonable to assume that the nature of choice will (and should) vary depending on the type of provision or service. It is the role of the statutory sector to balance the needs and preferences of individuals against the interests of their wider community. A statutory provider must also take account of effectiveness and efficiency. So, for example, individual choice is unlikely to be appropriate for refuse collection services—where a local authority is most likely to choose between a number of providers on an authority wide basis; but recycling services may be better suited to a neighbourhood solution; and personal care should take account of individual needs and preferences.

The concept of customers of public services

4.5 When providing a public service it is important to be clear who is the customer. The issue for many voluntary organisations delivering services under contract is that whilst they may consider the end user to be the customer, the statutory body for whom they are delivering the public service is also their customer. The reality is that most public services have a variety of customers—or stakeholders. The danger with the promotion of choice is that all the focus is on one customer, rather than on the range of stakeholders. Contracts need to make clear the relationship between different parties and be clear how contractors need to take account of other stakeholders.

Mechanisms for expressing choice

4.6 Two opposing problems can emerge when encouraging individuals or communities to express choice preferences:

— firstly, expectations can be unrealistic if mechanisms for choice are not carefully explained and managed; but also

— if offered too many choices or too much information the public can become overwhelmed and opt out of choice—this appears to have happened with energy providers for example.

4.7 A concern that many in the VCS have with choice is that the choice is for the contracting service provider, not the end user. It is often easier for the contracting authority to negotiate a single block contract with one agency. Such an approach can exclude small, locally based or specialist providers (who may be from the voluntary or private sector). However, whilst such an option might be easier for the statutory agency and appear to be the most cost effective solution, if real choice is to be provided to the end user it might be more appropriate to develop a package or consortium approach which would allow specialist and locally based services to be provided more effectively.

4.8 Where a variety of choices are made available to communities or individuals clear information needs to be provided about the choices available to them and honest and impartial information about the differences between different options. VCOs can play an important role providing advice and information to service users, particulary vulnerable people, about the options available to them.

4.9 Whilst targets, league tables, surveys and complaints systems can play a part, they do not necessarily provide meaningful information. There has been increasing research recently to suggest that targets and league tables do not improve performance, instead they can provide perverse incentives for service providers to focus on those items that are the subject of targets at the expense of other activities. And the reality is that all service users would prefer to access services from an organisation at the top of the league table—even if every organisation is performing to a level considered acceptable or good. Clearly not everyone can use the top performing service provider. This means that service users may feel dissatisfied even when they are receiving an appropriate service to a high standard.

Choice and equity

4.10 One of the distinctions between the public sector and other sectors (including the VCS) is that when undertaking any activity, including delivering public services, the public sector must operate equitably. It must also operate in the wider public interest, not in the interests of a particular individual or community. Equity is widely understood to mean that people have access to the services they need regardless of where they live, their gender, race or their income. Introducing a greater element of choice into the agenda inevitably makes it harder to balance the needs of the whole community against individuals or groups and can increase the risk of creating or exacerbating unfairness.

4.11 Promoting choice does not necessarily mean that there will be losers. In many cases it depends on the service being provided. There is no reason why, for example, a meals on wheels service cannot ensure that every customer receives their choice. However for many services if there are not to be winners and losers it will depend on sufficient capacity existing to meet the choices of each individual or community.

4.12 It is often the case that the private sector will "cream-skim" the least resource intensive, most profitable services, whilst many voluntary organisations tend to provide services to the most disadvantaged communities and the individuals, which tend to be more expensive. This should not be an issue if contracts are costed properly. Contracts should be developed based on the actual costs of delivering a particular service, not a block contract or per capita basis that applies across the board to all contractors. Statutory providers should expect to purchase services on a full cost recovery basis. If choice is to be extended government must recognise that it has to meet the costs of choice; it cannot expect other sectors to subsidise choice.

Information for users

4.13 As already said in paragraph 4.8 above, if service users are to be able to utilise choices available to them (and in order to ensure equity) it is essential that they have easy access to clear and impartial information about the options available to them. Statutory bodies have a responsibility to ensure that this information is made available, whether or not they directly provide the service.

4.14 Voluntary and community organisations play an important role in helping people to understand and access the choices available to them, particularly vulnerable people or those communities which the statutory sector often finds it hard to access. VCOs can also help statutory agencies to decide (in consultation with users) what information users need in order to make decisions, and to ensure that information is made available in appropriate formats.

4.15 If public services are to be reformed or developed in ways which increase the need for users to make informed choices, then resources also need to be set aside to fund those organisations that provide the necessary information, advice and support. This a clear part of the costs of the choice agenda. It should not be assumed that VCOs have the capacity or resources to provide increasing levels of support to users to support and/or subsidise the government's reform of public services.

Voice and public services

4.16 There is a tendency in the public services debate to focus on choice rather than voice. However in many cases users do not want greater choice—or it may not be viable. People want to know that their needs and concerns are being taken into account when public services are designed and delivered—to know that they are being listened to. It is important that as much attention is given to ensuring that voice mechanisms are effective as is given to promoting choice.

4.17 Voice can be treated as an individual or a community mechanism. All too often the debate focuses on the individual rather than the community. However, the role of government is to balance the competing interests of some individuals with those of the wider community. It is important therefore that when encouraging individuals or communities to express their preferences or needs that expectations are managed. Being asked what service you want or how you want it delivered does not mean that every individual (or even every community) will get what they want. Consultation should be about those things that the individual or community really can have a say over. And it should include a feedback process to ensure that those consulted know the outcome of the consultation and the reasons for decisions.

4.18 Voice is also about much more than ensuring that a complaints system is in place. Complaints should be seen as the final stage in the process when other aspects of voice (or indeed choice) have gone wrong. Of course the fundamental mechanism for voice in public service delivery is that most (but not all) public service providers are accountable to the community through the democratic system—voting in national or local elections. However the electoral system is a very blunt instrument. There need to be more targeted mechanisms for engaging stakeholders. It should include a range of mechanisms that are adapted for different circumstances and different services and which are directed at both individuals and communities.

4.19 Voluntary and community organisations can play an important role here because they can help statutory authorities to access particular communities, they can help to facilitate consultations, and they can act as advocates for individuals or parts of the community. There can be a tendency in parts of government to see the VCS as a service provider and either fail to recognise its role in advocacy, or even to argue that it is not appropriate for the VCS to both provide services and undertake an advocacy role. Some parts of government also put a lot of emphasis on talking to "real" people, rather than to representative and advocacy groups. However VCOs can play a valuable role in bringing people and communities together and giving them a collective voice. Government needs to recognise (at all levels) the important role that VCOs play as advocates and the contribution that this role can make to improving public services.

4.20 Many voluntary and community organisations have a lot of experience of direct user engagement in services. Many VCOs are user driven, and there has been a move to ensure that mechanisms are in place to enable stakeholders (which for VCOs might be users, donors, members or funders) to contributue directly to the work of organisations. An example of greater user focus is the RNID changing its name from the Royal National Institute for the Deaf to the Royal National Institute of the Deaf. Greater user engagement helps to ensure that services are more appropriately targeted and delivered. It also gives the users a greater sense of ownership of the services they receive.

Devolution and diversity

4.21 Voice should be capable of being exercised at all levels of public service provision. As has already been said, the applicability of choice will vary between services. However there is scope to increase community engagement, community voice and community choice in services specific to particular communities (of interest or geographic). Whilst some services need to be determined or delivered on an authority-wide, regional or national basis, others do not. And where they can be delivered in a way that makes them closer to the user, every effort should be made to do so.

4.22 Achieving greater diversity in the services available to the public, in order to reflect diverse needs and preferences, should be one of the driving forces behind offering choice. Diversity is about the needs of the public, not about the providers. Diversity is not achieved by having a mix of good and bad performers, nor is diversity about unique selling points of the providers. Diversity is about providers recognising that in many services one size does not fit all, and that services should be provided in ways which respect and address the different needs and preferences of different individuals and communities. In order to meet the needs of a diverse community, services may need to be purchased from specialist providers (those with a "unique selling point" such as a faith school), but could equally be provided by a single mainstream provider offering different choices.

Choice and the public good

4.23 There is a strong case to say that whilst the consumer generally should be sovereign in public services, that does not necessarily mean that each individual consumer can be sovereign. As has already been commented, the statutory sector has to develop and deliver services which balance competing demands from the public (or different "publics") and endeavour to ensure equity. Services must be designed and delivered in ways which promote the public good (not the convenience of the provider) but in the case of many services that may mean that compromise is necessary.

4.24 If choice is to be expanded in public services thought will also need to be given to the impact that the choices people make can have more widely. This has been recognised in relation to equity (discussed above). However it should also be recognised that choices made in one field of public policy can impact on other social policy aims or the wider public good: for example, if large numbers of parents choose to send their children to a school that is further away from home, social objectives of increasing the amount of exercise undertaken by children and reducing car use may both be affected, whilst local social capital and social cohesion may be weakened because those families feel less tied in to the local community.

4.25 Whilst individual choice can have risks of wider public benefit and social cohesion, encouraging greater voice and choice for communities can help to enhance understanding of community benefit: where individuals come together to make decisions about their local community then they have to take account of competing demands and what meets the needs of the community as a whole.

Capacity in public services

4.26 Giving an increasing role to community voice and choice when developing and delivering public services may have some cost implications—depending on how it is done. Offering the consumer the choice of a range of different providers or different services may have cost implications. Encouraging providers to develop services in ways which takes account of preferences or which builds in the scope for choice will have lower cost implications. However it should be borne in mind that if the purpose of choice and voice is to improve public services so that they better meet the needs of users, then any increase in costs should be offset by an increase in the effectiveness of those services.

4.27 Allowing greater choice may mean that extra capacity is needed: the private sector provides choice by costing in excess capacity. The public sector may choose to go down this route. If it does so it should not expect the costs of providing extra capacity to be transferred to providers in other sectors.

4.28 However greater choice can also be achieved by taking greater account of voice at the very earliest stages of designing and developing a service. Allowing greater voice and choice may mean that it takes longer to set up and develop a service—this may result in an increased up front cost. But it should mean that in the longer term services can be delivered more effectively and that there are higher levels of customer satisfaction.

4.29 Given our comments above, it should not be assumed that user charges are an inevitable outcome of greater choice. Instead choice and voice need to be understood more broadly. User charges move public services further down the route of individualised rather than public services. There is also a significant risk that user charges create inequity: charges limit choice to those that can afford to pay.

Raising standards

4.30 A key part of the government's agenda in relation to public services is to raise standards. However care should be taken not to assume that promoting choice will automatically enhance standards and accountability. It is not necessarily the case that standards will be driven up because the customer has the choice of other providers. Evidence from the private sector and the privatised utilities show that very often the consumer does not change provider, the normal comment is that they do not want choice they just want services provided properly, added to which they rarely have confidence that other providers will perform any better. Added to this, it is often the case that many service users do not realistically have other choices.

4.31 Increasing the role of voice may help to improve standards, however. If service providers are more aware of the needs and concerns of service users, they should be able to develop more effective services that reflect those needs and concerns.

Policy Team
NCVO

April 2004

Memorandum by the Royal College of Nursing (CVP 08)

Introduction

With a membership of over 360,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

We are very pleased to have the opportunity to be able to respond to the "Choice, Voice and Public Services"—issues and questions paper issued by the Public Administration Select Committee (PASC). We have previously issued responses to the "Fair for All" consultation paper from the Department of Health[4] and continue to be interested and involved in this aspect of the debate around the modernisation of the National Health Service. Our responses therefore concentrate on choice in health care with particular reference to the current NHS choice agenda.

[4] Fair for All—DH, 2003.

Defining Choice in the Public Sector and the Concept of Customers

Question 1 *How is choice in public services to be defined?*

Choice is a contextually ambiguous term, particularly in relation to the public services. Delivering what patients want, and delivering a range of choices, are not the same thing, although they are related.

RCN is concerned about the simplistic use of the word "choice" in many public consultation documents and debates relating to health care. Whilst we would not argue against expanding and improving patient choice, we would challenge the policy message that choice is always "a good thing" or that choice means the same thing to all people (*see Questions 11–12 below*).

Choice within current public service delivery must always be considered within the context of a limited budget funded from taxation; how that budget is distributed; and the role organisations and individuals play in the distribution and consumption of that limited resource.

Question 2 *Will the nature of choice vary depending on the type of provision or service?*

Choice is not always possible because health care needs are so diverse. For example, the unconscious road traffic accident patient cannot exercise choice over the care they receive in the first stages of their treatment, but may be able to choose different recovery pathways later.

Patients who suffer cognitive impairment or have learning disabilities or mental illness may have a limited ability to understand all the choices available to them; or they may lack the skills to communicate their preferences. In this case, advocates may assist them in making choices or the state may act as the patient's guardian via statute.

Therefore "Choice" is certainly not universally available to all patients all of the time for sound practical, professional or "moral" reasons.

Questions 3–4 *Is "choice" simply a euphemism for competition and market mechanisms?*

Is it possible to have customers of public services as well as active citizens and democratic accountability or are they mutually exclusive?

Choice can mean any number of things to any number of people. RCN has noted that not all aspects of this area have been publicly debated, particularly in relation to the greater use of market forces in the delivery of healthcare. We would want to see a broader more accessible debate around choice particularly in terms of clarifying exactly what is meant by choice and what the implications may be for the NHS, the public and our members who work delivering health services.

We have been concerned that the use of the word consumer in relation to choice suggests that there is a view that market forces and "competition" are the only drivers for quality improvements, increased efficiency and value for money—this is a simplistic view of what motivates improvements in services. The RCN believes that the current emphasis on consumerism appears to favour individualism over community and undermines democracy by encouraging a "complaints" or "exit" response as a means of expressing dissatisfaction rather than holding elected representatives to account for the national health service delivery. We also believe that it could exacerbate inequalities, particularly for people who do not have the resources, capability or societal status to exercise choice.[5]

The RCN has not seen any evidence that the public can be both consumers and responsible citizens and that this form of marketisation enhances democracy. Active citizenship and democratic accountability are possible without consumerism. This can be achieved through enhancing contact between elected bodies and the public; new forms of localism and mutuality; a more meaningful dialogue between policy makers and communities.

Mechanisms for Expressing Choice

Question 7 *Are targets and league tables, customer surveys and complaints systems sufficient for ensuring adequate responsiveness to consumer preferences?*

The RCN has repeatedly stated its opposition to an over reliance on centrally imposed targets and league tables. Whilst we have seen some improvements in some areas of patient care, our members have told us how they distort clinical priorities and expenditure as the targets have not been as patient focused as they should be.

[5] Citizen-consumers—New Labour's marketplace democracy. C Needham (2003).

Any new set of standards must be more patient focused and applied in an equitable manner ensuring the NHS continues to deliver locally focused, accessible care—free at the point of delivery.

There have been significant recent changes to the NHS, most notably an increase in the number of providers of services, including the independent sector and overseas companies. Any system of standards must ensure that there is an appropriate balance between local freedom and autonomy and central systems that protect NHS principles regardless of who the provider is.

The key question should not be whether or not such indicators support consumer preferences, but how do we make such indicators useful and meaningful for patients wishing to access health care.

Questions 9–10 *Can individual choice, collective choice and choice on behalf of the citizen (by Government or Local Authorities for example) operate successfully alongside each other?*

Are all these forms of choice equally effective in ensuring (a) efficiency and responsiveness and (b) equity and fairness?

Individual choice, collective choice and choice exercised on behalf of the citizen (eg by government) can operate effectively alongside each other providing there is honesty about the extent to which choices can be made; what the resource implications of those choices are; and the motivations of the state in making choices on behalf of individuals.

Choice on its own does not ensure fairness and equity or efficiency and responsiveness. To suggest such is to over simplify what motivates the workforce in health care or what motivates the public in identifying and seeking to meet their health needs.

RCN members overwhelmingly tell us that they enjoy being able to deliver effective, quality care. To do this they require the right number of appropriately skilled professionals in the work force, adequate and realistic resources and time to care and communicate with the public. We are concerned that the mechanisms used to facilitate choice in their current form are likely to continue to distort clinical priorities or be so detailed as to be meaningless to the public.

Choice and Equity

Questions 11–12 *Is there a generally understood definition of what equity means in respect of public services? Does equity currently exist in public service provision? If not who have been the main beneficiaries and why?*

Must there necessarily be losers in a system involving choice and contestability?

It is important to clarify what is meant by equity. Does it refer to equity of access? Equity in terms of clinical outcomes?

The Prime Minister has praised choice of provider as a means to "enhance equity by exerting pressure on low quality or incompetent providers"[6]. By this we assume he is referring to equity in outcomes. This distinction is important given the variable outcomes experienced by the UK population for example in terms of cancer survival rates even though cancer services are covered by a National Service Framework.

RCN is not aware of any empirical evidence that supports the view that choice will necessarily ensure equity of delivery in terms of the equal treatment of people in equal need[7] or that it will deliver the desired gains in quality or efficiency[8] or that it will address the disparity in the equity of outcomes.

On one hand we would support the principle that patients should be able to choose an appointment time, choose from the various treatments on offer, or perhaps choose a particular kind of practitioner. However, this raises questions of capacity, availability and access which we address below, and also offers challenges to service planners in ensuring equity across the service when faced with increasing public demand.

For example, individuals may choose treatments that are the most effective ie that best meet their preferences, but they may not choose the most cost-effective. Their choices may not reflect the preferences of society as a whole. Such choices may have corresponding costs for other service users in terms of lost opportunities for health care through loss of resources or services. One patient's choice may deny another's treatment[9].

[6] Rt Hon Tony Blair MP, 2003.

[7] The Real Cost of Patient Choice—Kings Fund, 2003.

[8] Applied Economics (9th Ed)—Griffiths and Wall, 2001. Based on an analysis of the improvements noted under the previous internal market, which some argue has for all intent and purposes been reinstated by the current government.

[9] *Ibid.*

The current system of "payment by results"[10] may facilitate the flow of resources to enable choice. However we are concerned that hospitals may lose patients to other providers through patient choice. These hospitals could then face loss of income and a declining spiral of funding, resulting in poorer services for those patients remaining with their local hospital. The result of such choices could be a widening of inequality in service provision and increased costs for those in society unable to relocate or travel to receive the "better" services.

Equity has several elements, each of which may be weighted differently by politicians, policymakers and the public. For example, equity of service may be taken by the public to mean all services, available to all people, all of the time, free at the point of delivery. This of course raises the irreconcilable conflict between allowing unconstrained choice of treatments that are free at the point of delivery, and the distribution of resources in a cost-effective manner within a fixed budget for healthcare.

In economics, consumers are assumed to act rationally, assimilating and processing all the relevant data, ranking their preferences and acting upon them.[11] However, at times of need or vulnerability patients may want to have a radical or experimental treatment "on the NHS" or may seek to receive "everything, right now". Whilst this might be seem reasonable request, delivering this within constrained resources requires an honest debate about what choices can and cannot be delivered.

As well as exercising what might be termed "unreasonable" choices, some patients may also choose not to choose. Current policy seems to be based on the argument that the general public wants to be heavily involved in making choices about their care almost without limitation. However, when people's health or social situation makes them feel more vulnerable, their views on how much they would like to take control of decision-making and choice can change.

Therefore the limitation on choice is a decision society should make in an honest and informed debate, and not be left to the vagaries of the market.

We offer the view that the NHS already embodies equity in choice in that it provides hundreds of different services free of charge to the public who otherwise would have their health choices limited by their income.

Question 13 *How can a choice-based provision of public services avoid providers "cream-skimming" the less difficult or resource intensive users of the service?*

"Cream skimming" is a well documented side effect of the "marketisation" of services[12] as is "adverse selection". Both are due to asymmetry in information either on the provider or user side and require intervention through regulation.

If one provider is allowed to choose lower risk/low cost clients by virtue of its market dominance the remaining high risk/high cost clients are left to be treated by other providers who may then display apparently worsening efficiency or clinical outcomes.

This may have the effect of reducing choices of provider available to patients who are considered to be high risk/high cost. In their study of US Chronic Disease Management, the Kings Fund found that where there was competition between MCOs (Managed Care Organisations), it could lead to a focus on attracting young healthy enrolees at the expense of people with chronic disease. They also noted a distinct lack of focus on social care[13]. There are already elements of *de facto* cream skimming for some types of treatment centres which by virtue of the type of care delivered are only available to certain people (ie those who are otherwise fit, have a large degree of self care, have highly developed support mechanisms and transportation, etc).

One solution might be to draw up a contract for services which includes requirements for certain kinds of services to be delivered by all providers all of the time and that captures the clinical outcomes required for each service. To accept the need to regulate in such a way is to accept certain intrinsic failures of a market approach to the provision of health care, as it will never be possible to provide symmetry of information for *all* providers and users *all* of the time.

Hence the RCN would argue that there will always be winners and losers in a free market either:

- by virtue of the patients' social status (mobility, income, etc);
- educational status (the degree of ability in reading, writing, effective self advocacy, etc); and
- ethnic or racial origin (whether or not English is their first language, whether the services are designed around black or minority ethnic group's needs, etc).

[10] Implementing the new system of financial flows—Payment by Results: Technical Guidance 2003–04. DH, 2003.
[11] Citizen-consumers—New Labour's marketplace democracy. C Needham (2003).
[12] Applied Economics (9th Ed)—Griffiths and Wall, 2001.
[13] Managing Chronic Disease—What can we learn from the US experience? J Dixon & R Lewis et al, Kings Fund 2003.

VOICE AND PUBLIC SERVICES; DEVOLUTION AND DIVERSITY

Questions 17–18 *What mechanisms (complaints, feedback) exist or should be created for exerting influence on providers? Are they available to all?*

Does the complaint system operate effectively and equitably in the public sector? If not what should be done to improve this?

Many NHS reforms include new forums for engaging the public in local decision-making about services or as guardians of local interests. There are benefits to this approach in ensuring a new kind of accountability and encouraging community "buy in" to local service design.

There has been much less research conducted regarding the benefits of public involvement in health care. Arguments in favour of this approach relate to more wide ranging issues such as equity, responsiveness, and democracy. It is useful to broaden the scope of evidence in this area to include practical impact. For example:

- The Cystic Fibrosis Trust has developed a network of 14 patient advocates in the UK. They represent the views and concerns of people with cystic fibrosis to clinicians and health service managers in order to shape how services are designed and provided. This role is valued by patients.
- Many practical examples of person-centred changes are described in *Signposts* (National Assembly for Wales 2003). This features brief case studies of a range of projects to increase patient and public involvement in health care. Successes are reported although few have been subject to academic research of effectiveness.
- The Expert Patient Programme (Department of Health 2001c) has shown some practical impact within pilot sites and will be refined and rolled out more widely.

However, anecdotally we note a distinct lack of clarity and public understanding around the constitution and authority of some of these bodies. In such a vacuum there might be unnecessary variation in the form or function of these forums, or they may simply become talking shops rather than genuinely influential patient groups.

The RCN is keen that such forums do not become dominated by secular interests. More work should be done to ensure that forums can be truly representative of the community they serve in terms of recognising diversity, the traditionally disenfranchised and the socially excluded. For example, people with debilitating physical illnesses or chronic mental illnesses, may not be equipped or able to attend a public forum to discuss service design for their health needs. Alternative mechanisms must be found for these and other groups for whom exercising "voice" is complicated.

The RCN held a seminar with patient organisations in January 2004 entitled *A Partnership for the Future: the Future Nurse and the Future Patient*. The discussion focused on three main issues:

- the possible health care needs and health seeking behaviour of patients in the future;
- how "person-centred care" will be perceived in the future;
- how the future nurse can support the future patient.

The findings of that seminar have been reported in full elsewhere.[14] Some of the key points particularly relevant to the above questions were:

- There will be increased access to health information in the future but the ability and willingness of patients and communities to assimilate and interpret that information will vary, dependent on circumstance and individual preference. Health care workers must become proactive in order to ensure equitable access to information and services.
- Communication must be two-way and the needs of those not able to speak out with confidence not neglected. There is a long way to go before the views of those who do not attend public meetings or forums are sought.
- Patients want someone to fulfil non-clinical roles such as befriending, particularly in mental health. They greatly appreciate good interpersonal skills and high quality essential care from nurses, in addition to expert clinical practice.
- The concept and practice of partnership working with patients should be integral to all nurse education and introduced at the start (and likewise across all health profession education).
- Nurses need to be kept up-to-date with technological and scientific advances so that patients and the public realise the value of their contribution to health care. The examples of e-health and ways of helping people learn to speak after a stroke were put forward.
- Generally nurses are already seen as the health care professionals closest to patients concerns and the patient experience. They have the potential to build further partnerships that can challenge un-patient friendly policies and procedures.

[14] Report of Seminar: A Partnership for the Future: The Future Nurse and the Future Patient. Edwards, Naish and Stanizewska 2004, www.rcn.org.uk.

— Individual patients benefit from being given the time to communicate, both to feed back on their perceptions and ask for information and clarification. This time is highly valued and crucial to person-centred care and should not be squeezed out.

— The public and other health professions need to be educated about the potential of nursing for changing health care systems and practice.

If service design is going to genuinely reflect community needs and mitigate against individualism or niche interests, then the above issues need to be addressed urgently.

Choice and the Public Good

We have already addressed our concerns over the conflict between individual choice and collective or public good (*see above*).

In summary, to put the consumer as "sovereign" is to risk placing individualism over community; undermining democracy and exacerbating inequalities, particularly for people who do not have the resources, capability or societal status to exercise choice.

Capacity in the Public Services

Questions 26–27 *Will the extension of choice create unmanageable demands on the capacity of public services to provide? If so is some degree of excess capacity necessary for choice to operate effectively?*

What are the cost implications of this? Should it lead to an extension of Private Finance Initiatives?

There is evidence of the impact of choice on public service capacity already in the education system. Every year, "consumers" of education (the parents, not the children) make choices to send their children to the "best" secondary schools based on widely available league tables. Many however find they are disappointed as there are no places or the school has redrawn its catchment area[15]. Anecdotally we are aware that affluent, mobile parents therefore move house to ensure that they get the best "choices".

The RCN maintains that adequate capacity is essential if the NHS is able to re-allocate its resources in favour of the services or providers that people choose over others. We suggest that by setting up the expectation before setting up the structure, patients are denied the choice (ie to go to another provider) and can only use their voice (ie complain). The increase in complaints can reduce morale and damage relationships between the public and the services.

> "Until there is . . . some surplus capacity within the system, for most people wanting to educate a child or book an operation, choice will be as academic as it was for Henry Ford's first customers"[16]

This capacity can be provided through public private partnerships. However we have several concerns about the PFI process which we have previously brought to the attention of the Health Select Committee[17]. In summary:

— The economic case for PFI over the public sector comparator has not been made.

— Evidence from our members points to a design process which is exclusive rather than inclusive; unhelpfully concerned with commercial sensitivities to the detriment of good design; cost orientated rather than orientated around the patient journey.

— There is evidence to suggest that good design can have a direct impact on clinical outcomes and the morale of the building's users[18];

— Whilst initial prices may be low in comparison with the Public Sector Procurement route, the overall costs of PFI are higher than the PSC.

— Our members have expressed concerns about this transference of ownership due to the lack of clarity around risk sharing arrangements.

— Notwithstanding the above, there is a lack of transparency which makes true comparison difficult. This is often excused by commercial sensitivities around the tendering process.

Question 28 *Are user charges an inevitable outcome of greater choice? Might user charges help widen choice?*

The RCN firmly believes in a national health service, available to all, free at the point of delivery funded from general taxation. There are some who suggest that current reforms expanding the system of charges—current Government policy around tuition fees suggests a willingness to engage in some form of debate around this theme[19].

[15] The Impact of Selection—*The Guardian,* 4 March 2004.
[16] Op Cit.
[17] The role of the private sector in the NHS—Evidence to the Health Select Committee, RCN, 2001.
[18] See for example RCN and CABE joint press release and campaign Healthy Hospitals, RCN 2003.
[19] IPPR health policy seminar. Not for profits and patient choice: the route to better healthcare? IPPR, 2002.

International evidence suggests that insurance based systems lead to some equity and access concerns. For example in the USA, it is estimated that over 40 million people are not insured (projected to rise to 52 million by 2006); at least 1 million people lost their health insurance in 2002 *whilst in full time employment* ie the scheme was withdrawn by the employer; employers are increasing the level of employee contributions to the co-payments scheme by six times the level of general inflation[20]. In France, they are making steps back towards a higher percentage of tax based funding following concerns over equity of access; in Germany, the level of access to different health funds in dependent on your income[21].

Given the above international evidence, the RCN is not convinced that any element of charging in relation to health care enhances choice, improves equity or improves quality of services to patients.

CONCLUSION

— The RCN is committed to a National Health Service free at the point of need, funded through general taxation. There are aspects of the current Choice agenda which may be considered a threat to that position although this needs to be investigated further.

— Genuine improvements in health and health care choices for all are welcomed by the RCN. However they must be accompanied by a suitably robust and informed public debate about the implications of such a move; a suitable infrastructure; and appropriate arrangements to ensure the interests of the most vulnerable and voiceless in society are protected.

— There is insufficient evidence available to be able to judge the effect of greater patient choice in the UK health care environment. International evidence is available but must always be considered on the understanding that the NHS is a unique construct and has no obvious comparators.

— The RCN has concerns that in the absence of the above, patients are liable to become increasingly consumer-orientated in their relations with the NHS: in that they become consumers of the options chosen for them by regulatory systems designed to mitigate against market failure; and aggressive complainers about the NHS real or imagined faults rather than engaging with democratic processes which may be more successful in raising the standards of care for all members of society.

— Consultation exercises and patient involvement forums must be transparent, accessible, and honest and give realistic options to the public about which areas of service design, cost and location they can choose and which they cannot for whatever reason.

— Choice must be informed choice. It is crucial that staff are adequately trained and supported to facilitate the information seeking and decision-making of a diverse range of service users. Nursing is a profession that works closely with patients, carers, service users and the general public on a day by day basis, and often over long periods of time. Nurses are ideally placed to help patient's access information, interpret it, evaluate it, make decisions, and follow through the choices made.

Memorandum by the New Local Government Network (CVP 09)

The New Local Government Network (NLGN) welcomes the Public Administration Select Committee's (PASC) inquiry into choice and the role it can play in reforming and modernising public services. The PASC inquiry paper outlines many issues that need to be addressed when considering introducing and increasing choice for service users and we will look at them in more detail as part of this submission. However, this memorandum is very much to be read in conjunction with our published report "Making Choices" which has been submitted separately.

The current debate around choice has become confused and largely polarised with some commentators regarding choice as the panacea for all problems currently besetting public services, and others fearing that choice equals privatisation and that its introduction would lead to greater inequity, post-code lottery and the loss of the public service ethos. Choice is a very complex concept with many facets. So far the discourse has been far too narrow, focusing largely on one type of choice: individual user choice over provider and almost entirely ignored collective choice and choice over how a service is delivered rather than who delivers it.

NLGN supports the attempt to bring some clarity to the choice debate to ensure it reaches well beyond political rhetoric. We regard choice as an important tool as part of a public service reform agenda that tries to make services more responsive to users' needs and ensuring that services evolve in line with public choices rather than professional or producer preferences. However, we disagree with the view that choice is a good in itself and should be implemented in all service areas at all costs. It has to be applied under the correct conditions if negative effects on equity and service standards are to be avoided or minimised.

[20] US Health Care Crisis and Directions for Reform—National Coalition on Health Care, 2004.
[21] *Op Cit.*

Background

In March 2004 NLGN published its *Making Choices* report, the result of an eight-month research project that addressed many of the issues raised in the paper by PASC. The NLGN research particularly focussed on choice in local public services and drew its case study material largely from examples of choice models used in local government services.

We regard the extension of user choice as part of a wider debate about how we can modernise public services and understand the concept as one way of ensuring that services evolve in line with public choices and that they become more responsive to the needs and desires of individuals and their communities. The report carefully examines benefits and problems arising from enhanced choice and demonstrates that these are influenced by the conditions under which choice is widened rather than resulting from the inherent nature of choice.

Below we will consider some of the issues in more detail.

Defining what choice means in the public sector

There is considerable confusion over what enhanced choice actually means. The different participants in the debate—academia, think-tanks, central government, local government, the wider public—all work with differing definitions of choice of varying validity. The NLGN study "Making Choices" defines enhanced choice more precisely as "delegated decision-making" whereby choices once made by professionals are made instead by service users.

This is not to denigrate in any way the potential transformation of public services caused by mechanisms that substantially increase the role and influence of user voice in individual services. We do, however, feel that the issue is confused when voice mechanisms are referred to as enhancing choice.

We do not feel choice should be regarded as a good-in-itself to be applied universally across all local authority services, but we have concluded from our work that greater choice works best when it meets the following three criteria:

- it resolves a problem with service delivery;
- the problem can be perceived by users through their direct, day-to-day experience of the service;
- the operation of user choice is integral, rather than incidental, to the resolution of that problem.

Only when these criteria are met, can users be sure that the extra costs they incur when making choices are worthwhile.

Choice can be about diverse providers (which may or may not include the private sector) and contestability, but choice can also be delivered by one provider (public or private) providing a range of options.

Our case studies have illustrated that choice in local public service delivery can indeed mean many things. The two major case study areas we have identified where elements of user choice have been introduced could not be more different. Direct payments in social care offer users increased choice by delegating financial resources completely to individuals to "purchase" the care they want from the public or private sector. In this way it introduces new providers and hence greater capacity. However, this does not always work in practice, eg in rural parts of the UK acute care personnel shortages exist and users effectively have no choices available due to the limited capacity. The choice-based letting scheme in housing in contrast is about rationing a scare resource. Choice has not increased overall capacity; no more social housing is available to tenants. However, the nature of the housing service has fundamentally changed through the introduction of the bidding schemes. The old system was opaque and often unfair; the new system is open and transparent service that responds to user choices. In both cases users have become empowered to make life choices that were once made by local authority professionals.

Collective choice

A weakness in the current debate is that it focuses largely on individual user choice. However, we feel that collective choice by groups of users is also worthy of consideration. There are some services, particularly those dealing with the public space or those requiring considerable strategic co-ordination, where individual choice is not suitable or possible. Collective choice can also address some of the concerns about equity by encouraging pooling of resources between users and equalisation through democratic procedures; it can also allow local democratic representatives more influence over user choices than might exist with individual choice. Clearly collective choice links to several other agendas we have worked on, including neighbourhood and local governance that come under the banner New Localism (Corry and Stoker (2002) *New Localism: Refashioning the centre-local relationship*, NLGN; Corry *et al* (2004) *Joining-up local democracy: governance systems for new localism*, NLGN).

Choice and equity

One of the most controversial issues when considering widening user choice in public services is equity. Some commentators believe that enhancing choice must have a negative impact on equity and argue that it exacerbates existing inequalities; encourages market-type reasoning into public services; polarises the quality offered by different providers with the less well-off receiving the poorer service; and that middle-class users who are rich in resources such as information and inter-personal skills have a considerable advantage. Others believe choice enhances equity and argue that it offers choices to the poor that have always been available to the wealthy; improves access to higher quality services for the poor; and keeps the middle classes and their tax contributions within the public sector.

The NLGN report concluded that the probably most powerful argument for enhancing choice without diminishing equity is that by offering choice to poorer users one is positively enhancing equity since such choice has always been available to the wealthy. The latter are free to use their money to exit the public sector and purchase services from the private. This has been the case particularly with healthcare, education and long-term assistance and care for the disabled or elderly.

The research considered in the study suggests that the direct payments and choice-based lettings schemes can offer a high degree of equal choice to all users. However, such schemes come at a price—particularly in terms of building capacity and support systems (although not necessarily any higher overall than normal provision without choice). However, for choice to really increase equity without exacerbating existing inequalities a very great deal of effort has to be put into the equalisation of resources between the resource rich and resource poor.

Choice and capacity

Capacity is another key issue when considering widening user choice. Choice and user preferences are only real if the capacity to respond to them exists. In particular, offering greater flexibility over the timing, location and range of options for a service will sometimes incur extra cost and will almost certainly require some expansion or redirection of capacity in regard to staff skills and possibly institutional structures. The issue is important because while services with much greater choice over service form can drive up service standards and equity by reaching new marginalised or under-resourced groups, the way capacity is built and the way costs are met may diminish or enhance these benefits.

Choice does not need to imply anything about user charges. However, it may be helpful to comment on them here. For certain services, it may be acceptable to employ user charges for an enhanced service above a minimum, because the benefits of purchasing the service do not have a particularly significant impact on equity. However, other services options—for example, those meeting minority religious requirements or basic educational needs—should probably not be subject to user charges on the grounds of equity. In addition, there must be some concern that if the provision of a wider range of service options and extra services becomes the norm in local government, then the better-off will be able to purchase a far better service overall—the cumulative result of choosing and paying for a wide range of alternative or extra service options—than less well-off users. Of course, the way these problems are normally dealt with is to subsidise poorer users through general taxation.

Limited capacity and provider choice can have serious effects on equity. Services facing higher demand, which will tend to be the better services, can choose less costly, more beneficial users ensuring their service improves while less popular services, likely to be the poorer services, are left to treat the more costly, less beneficial users leading to an ongoing reduction in their quality. This is particularly true in health and education, where this phenomenon is known as cream-skimming. In effect, therefore, lack of capacity turns user choice into provider choice and raises serious equity concerns. A mass of dissatisfied users, lack of clarity about why some choices are rejected, and overt manipulation of the system can be the result.

Strategies must be established to expand capacity by improving less popular providers or options and by encouraging other public, private and voluntary organisations to join the market to deliver a service. Increased contestability would give providers an incentive to respond more directly to user needs and evolve quicker.

The key concern for any provider entering a new market must be the balance of risk and cost against the potential reward. Greater choice has obvious risk and cost implications as providers no longer have guaranteed throughput.

Producer Conditions

Some staff and trade union representatives fear that the greater contestability promoted by enhanced user choice will lead to cuts in pay and jobs and poorer working conditions in order to provide a cheaper service. There are also claims that delegation of responsibilities to users will mean deskilling for the professionals.

This study found little evidence of job cuts and adverse conditions for workers. By contrast, there were some signs of improved job satisfaction under the choice schemes considered in the research.

Raising Service Standards

Some commentators believe choice has a detrimental effect on service standards and argue that it encourages providers to offer differing quality of services to users with different levels of resources; that it allows users to make inappropriate or ill-informed choices; increases the transaction costs of service delivery; and creates dissatisfaction amongst users who want good, convenient services not choice. Others believe choice has a beneficial effect on service standards and argue that it improves standards by allowing contestability between different providers; raises user satisfaction; and allows public services to evolve more effectively to changing user demands.

The NLGN study found that choice can improve the services available particularly to the resource poor but this is not an automatic process. Considerable time and effort have to be put into the moderation of pre-existing conditions if services are to be improved, quality polarisation is to be avoided and greater equity to flourish.

As with equity, the evidence suggests that the positive or negative impact of choice is dependent on the conditions under which it is implemented.

Information for Users

The research clearly demonstrated that authorities must ensure users are adequately resourced in terms of funds, information, personal skills and links to professional networks if they are to be able to make informed and successful choices.

The extent to which information is distributed and how it is presented is vital to building awareness of a scheme and encouraging take-up. Including the identification of those groups which might be hard to reach and ensuring that strategies are in place to make them aware of schemes and encouraging them to take part in the scheme if appropriate to their needs is key. Poorly thought-out information distribution and poorly-presented literature will have a negative impact on the equity of a scheme.

All professionals who participated in the NLGN research acknowledged that the sharing of information between users, frontline staff, management, different local authority departments and private and voluntary sector partners is absolutely vital if a choice scheme is to run effectively and to improve over time.

This is particularly important as the relative novelty of choice schemes means that lessons about choice are still being learned and this can only be done if the different elements of a scheme delivering or receiving different aspects share their experience. Also the emphasis on being more responsive to user demands requires that knowledge of those changing demands and the implications for service delivery is widely shared to ensure that all providers are working with rather than against each other. And since choice schemes often involve more providers and agencies than in the past, playing roles which might once have been carried-out entirely by the local authority, it is vital that information is fed freely to the key body charged with overall co-ordination to ensure that schemes are effective.

Thus procedures such as good data systems reporting, ongoing reassessment of user choices, the establishment of well-supported partnership groups, the creation of a culture of inter-departmental co-operation and professional flexibility and the encouragement of frontline staff feedback, all take-on an extra importance in public services characterised by choice.

Evaluation

The regular monitoring and evaluation of choice schemes is essential to establish whether users are satisfied with their choices and to identify the impact on equity and service standards. Questionnaires and telephone surveys are commonly used for this purpose, but our study found that many lack sophistication and response rates vary greatly. Local authorities need to think hard before implementing elements of choice about which mechanism would best assess the likely impact of increased choice on their services. They also need to be able to collect meaningful data on the impact of greater choice on cost, user involvement, staff satisfaction, provider capacity etc to be able to compare their choice schemes with previous service performance. Inspectorates like the Audit Commission must also seriously consider these issues.

Concluding Comments

The NLGN study has found that offering choice to users is no simple matter. Major shifts are required in working practices and new infrastructures have to be established to monitor and administer the operation of service provision based on user choice.

The enhancement of choice has the potential to have both a positive and a negative impact on equity, service standards and the working conditions of public service workers. Whether enhanced choice does have a positive or negative outcome in these areas relies heavily on the conditions under which choice is enhanced.

Given that the range of these conditions and of these ways of enhancing choice is so varied, there can be no sense that a "one-size-fits-all" model of choice exists. Indeed, enhancing choice should be far more about flexibility and open-mindedness in response to the particularities of each service and each scheme.

Many of the issues raised in the inquiry demand further detailed research.

April 2004

Catherine Needham, Queen Mary, University of London/Catalyst (CVP 10)

The questions that the Public Administration Select Committee (PASC) raises about public service reform are wide-ranging and complex. This memorandum does not seek to answer all of the questions, but responds specifically to question 4 on the relationship between the customer of public services and the active citizen. The memorandum argues that we need to understand what it means to be a customer in the public sector in order to assess the implications for citizenship. It draws on empirical data from qualitative interviews with civil servants, local government officers and councillors to identify three ways in which the citizen may be treated as a customer. These three models of customer interact differently with citizenship. The models also have different implications for personalisation and choice within public services, the subjects of other questions in the PASC inquiry.

The PASC Issues and Questions Consultation Paper on Choice and Voice in Public Services asked: *Is it possible to have customers of public services as well as active citizens and democratic accountability or are they mutually exclusive?* The answer to this question depends in large part on how the terms are defined. Citizenship is a term that is highly malleable and contested; it denotes membership of a political community, but beyond that there is little agreement on its manifestations. The active citizen looks very different when viewed through the lens of liberal individualism than when considered from the perspectives of republicanism or communitarianism. Disputes over the meaning of citizenship are well rehearsed elsewhere, and are not replicated here.[22] Citizenship is understood here to denote membership of a political community, necessitating collective choices and generating individual rights and entitlements.

More interesting and relatively under-explored is the question of what it means to be a customer of public services. Customer is a term increasingly used within central and local government. The PASC Issues and Questions Consultation paper noted the emphasis that the Prime Minister and the Office of Public Services Reform (OPSR) have placed on treating the service user as a "customer". The PASC could equally have found endorsement of a customer approach from Cabinet Secretary Andrew Turnbull and in several white papers on service reform. The shift towards the language of customer is also evident within local government. Content analysis of Best Value Performance Plans in eight local authorities found that the term customer was used six times as often as the term citizen.[23]

There is clear evidence that the language of customer is used within central and local government. How far is this language significant? One approach is to see customer merely as a synonym for service user, saying little of importance about the direction or content of public service reform. However analysis of usage of the term customer by those in government makes such an approach difficult to sustain. It is clear from the way that Blair and the OPSR talk about treating the public as customers that the language is designed to signify a shift in attitudes to public service delivery. When for example Blair says, "Instead of the old benefit mentality, individuals are treated as customers", he implies that being treated as a customer brings with it specific entitlements.[24] To be a customer of public services is to be treated in a particular way when using that service. It is this aspect of the term customer that makes it worth exploring.

A second interpretation of the term customer is that it is a private sector concept, related to a commercial relationship between provider and supplier. This is the understanding of the term customer given by Lusk, who argues that, "[B]oth "customer" and "consumer" orientations in social provision are equally the result of a "commercial" construction of the user/provider relationship."[25] To call public service users customers is thus to encourage them to view public services as extensions of their private sector consumption. This interpretation is hinted at in government claims that changing experiences of private sector consumption are driving expectations of public services.[26] If the customer is cast in commercial terms, it poses problems for any model of citizenship developed on the basis of the exclusion of commercial considerations from civic life.

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[22] See for example Faulks, K (1998) *Citizenship in Modern Britain* (Edinburgh: Edinburgh University Press) or Heater, D (1990) *Citizenship: The Civic Ideal in World History, Politics and Education* (Harlow: Longman)

[23] Eight local authorities in England were targeted for the research, which was undertaken during September 2003. The local authorities were selected to provide a variety of types, regions and political control, although the sample is too small to draw generalisable conclusions.

[24] Blair, T (2002) Speech on Welfare Reform, 10 June, www.pm.gov.uk/output/Page1716.asp

[25] Lusk, P (1997) "Tenants Choice and tenant management: who owns and who controls social housing?", in Cooper, C and Hawtin, M (eds), *Resident Involvement in Community Action* (Coventry: Chartered Institute of Housing), p 68.

[26] See for example Cabinet Office (1999) *Modernising Government*, Cmnd 4310 (London: HMSO), §1.5.

I have argued elsewhere about the potential for a customer or consumer orientation to pose limits for a participatory version of citizenship.[27] Rather than replicating those arguments here, I will take a different approach. Instead of presuming that customer has a commercial orientation, I draw on empirical interviews with civil servants and local government personnel to develop a sense of the extent to which those working in public services adopt a customer orientation and what they mean by it. From this it is possible to develop a better understanding of what the practical implications of a customer orientation will be for service reform and citizenship. The discussion below draws on qualitative interviews conducted with civil servants in the Departments of Health and Education and local government officers and councillors. The sample size is small (32 interviews in total) and the findings should be interpreted as guides to how customer approaches are developing in central and local government rather than generalisable findings about either tier of government.[28]

Interviews with civil servants in the Department of Health and the Department for Education and Skills (DfES) indicated that civil servants were comfortable talking about the service user as a customer. A member of the Corporate Development team at the Department of Health (DoH) stated:

> "It's a bit of language that is extensively used. I was on an interview panel yesterday and one of the questions was what do you understand in the context of this job by the term customer care. So the concept of finding out what the customer wants, devising what you can, matching expectations, setting standards and measuring whether you've met those standards, it's the sort of language that is being introduced." (Corporate Development team, DoH, Interview, 3 April 2003)

A civil servant in the Connexions Unit within the Department for Education and Skills (DfES) affirmed the wide usage of the term customer: "One of the DfES behaviours is about involving customers, and its about saying that everyone who works for the DfES should be driven by these behaviours" (Connexions Unit, DfES, Interview, 14 February 2003).

The civil servants interviewed indicated that they saw a shift to the language of customer as a positive development. A respondent from the Learning Disability Unit in the Department of Health when asked whether he thought it was useful to see service users as customers said:

> "In some ways I'm more comfortable with the idea of talking about customers than with talking about service users. It's much more helpful to think along those lines, to think what kind of service do you try to give to customers. What expectations should customers have of the service you give? How do you try to deal with the customer?" (Learning Disability Unit, DoH, Interview, 13 February 2003)

A member of the Youth Participation Team in the Connexions Unit of the DfES answered the same question saying, "I think we see our work as being driven by our customers who are young people" (Connexions Unit, DfES, Interview, 14 February 2002).

For these civil servants treating someone as a customer involved developing personalised services and responding to the needs of the user. It was not necessarily linked to the expansion of choice. As one interviewee put it,

> "The reality is that for some services that people need there is only going to be one provider, the best that the customer model can do is to keep everyone on their toes and make them think about the quality of service that they are providing and how far it's targeted at the needs of the individual." (Learning Disability Unit, DoH, Interview, 13 February 2003)

The customer care approach was associated with internal change ("keep everyone on their toes") and individualised care rather than necessitating an expansion in choice.

Within local government, interviewees were asked whether they felt it was helpful to see local people as customers. Nineteen of the 28 said that they did see the language helpful. Officers were particularly in favour of calling their users customers. Sixteen of the 19 officers expressed support for using the language of customer. Most of these felt that referring to people as customers helped to instil a certain "mindset" or "culture". One said: "I think that the reason we started to call them customers was to improve, it was to change our internal culture" (Head of Customer Services, London Borough, Interview, 3 June 2003).

The councillors interviewed were more sceptical about the word customer, with five of the nine expressing reservations about customer terminology. The councillors tended to see customer language as an erosion of the role of citizen and the democratic linkages between themselves and local people. One said: "No, they're

[27] Needham, C (2003) *Citizen-Consumers: New Labour's Marketplace Democracy* (London: Catalyst).

[28] Four interviews were conducted with civil servants in the Department of Health and the Department for Education and Skills. Respondents were selected for their involvement in policy matters relating to service delivery. In local government, 19 officers and 9 councillors were interviewed, drawn from the eight local authorities discussed in footnote 2. Council websites were used to identify senior officers with responsibility for service delivery, consultation and communication respectively. Two or three officers were interviewed in each authority: three from the larger authorities and two from the smaller councils where a single officer usually took responsibility for consultation and communication. One executive board councillor was interviewed from each of the eight local authorities. An additional interview was conducted with an opposition councillor in the county council to explore the backbench perspective.

citizens. We work for them, they elect us, they put us there, they can chuck us out" (Councillor, London Borough, Interview, 1 June 2003). Another said, "They're more important than customers—we're their servants," (Councillor, Rural Borough Council, NW, Interview, 10 September 2003).[29]

In the local government interviews, respondents were asked to explain what they thought it meant to treat someone as a customer, to explore the extent to which a consistent definition existed. Four broad approaches emerged. For a first group (5 of the 28), the language implied that users were paying for the service and so should receive good quality treatment. As one put it, "Yes, they are our customers; they pay for the service. They are all taxpayers, and we're the service providers" (Head of Communications, Rural Borough Council, NW, Interview, 4 September 2003).

A second group saw being a customer in terms of having choice. Six of the 28 respondents saw customers in those terms. As one put it:

> "Yes, there is a real move to looking at anyone who receives our services as customers, and there's obviously a lot more being done to actually enable them to choose what kind of services they want rather than the old idea of the local authority just systematically providing services." (Head of Communications, Metropolitan Council, YH, Interview, 5 September 2003)

Some of those who conceived of being a customer in choice terms recognised the difficulties councils faced in offering real choice. As one councillor said: "Customers can come and go—if you don't like Marks and Spencer you can go to BHS. . . People who live in [the borough] are bound to [the borough] council" (Councillor, London Borough, Interview, 1 June 2003).

For a third group (6 of the 28), customer language implied that local services and information were oriented to the needs of the individual user. As one put it, "I think what we'd be trying to say is to think of the individual and each one as being individual rather than thinking of 800,000 people at a time" (Director of Policy, County Council, WM, Interview, 22 May 2003). All respondents with service responsibilities recognised that there was a need to respond to individual needs, although in a modified way: "Around individual users would be difficult. Around groups of needs, that's what we're aiming to do. . . We would as near as we could provide a tailored service" (Head of Customer Services, London Borough, Interview, 3 June 2003).

This approach links closely to the aspiration of making services and council staff more accessible to the public, which is what a fourth group of interviewees understood by the term customer (7/28). As one officer put it, "[We] try and organise the council's administration in such a way that it's convenient to the customer and not convenient to the administration" (Chief Executive, Unitary Authority, NW, Interview, 26 September 2003).

A weaker variant of this model of responsiveness, invoked by a fifth group of respondents (4 of the 28), was that being a customer implied courtesy and respect. As one respondent said when asked what it meant to treat people as customers, "We will be polite at all times; we will ensure that everyone is treated fairly and with respect" (Head of Customer Services, London Borough, Interview, 3 June 2003). Some respondents linked this notion of customer to their council's Customer Charter. As one explained, "There is a customer charter which is a set of 10 promises, but they are more about style and respect than they are about a measurable service standard" (Head of Customer Services, London Borough, Interview, 3 June 2003). One interviewee talked of the council's "Customer First Promise", which set out what customers could expect from the council, such as a timely and respectful service (Head of Communications, Metropolitan Council, YH, Interview, 5 September 2003). Six of the eight councils had customer charters, although not all were accessible through the website and in some cases even officers were not aware of them.

These five conceptions of the public service user as customer (payment-oriented, choice-oriented, personalised, access-oriented and courteous) have different implications for the relationship between the customer and the citizen. Before considering these implications it is important to note the extent to which a customer focus was prompting internal change within the case study councils. Three of the councils had set up Customer Service divisions in their authorities, and all the councils had introduced "one stop shops" to enhance access. A new set of staff were being appointed, trained in customer care rather than a specific service area, whose role was to respond as effectively as possible to a whole range of customer issues:

> "We'll have people drawn in from the various departments with a generic training and the appropriate high-tech kit so that they have the information in front of them, to be able to give people the information with the first person they contact." (Chief Executive, Unitary Authority, NW, Interview, 26 September 2003)

All of the councils had introduced or were introducing Customer Relationship Management (CRM) software. CRM packages, adapted from the private sector, compile data about service users" dealings with the authority onto a database, which staff across different departments can access. One respondent explained how CRM works:

> "It's just a big database of customers who we've provided service to, and we add to the database when the customer contacts us. So we develop a history of that customers" needs and service requests from the council and their information needs. And in the fullness of time we should have

[29] Regions are denoted by standard abbreviations: SE—South East, E—East, SW—South West, WM—West Midlands, NW—North West, YH—Yorkshire and Humberside.

> the information for segmenting our market, so that we understand how to deal with different parts of the market better and more responsively." (Head of Communications, Rural Borough Council, E, Interview, 23 May 2003)

As at central government level, customer language was being used by the local authorities in their recruitment strategies. As one respondent indicated, "I was recruited just over a year ago to bring some of the customer care concepts and service performance with me from another authority" (Director of Policy, City Council, SW, Interview, 22 September 2003). Another interviewee reported that her authority used the term customer in job advertisements, which attracted new employees to the council:

> "It certainly has attracted people from outside the public sector to the jobs here, and so we have people with a different approach who see our customers as the centre of their world rather than an intrusion into their world." (Head of Communications, County Council, WM, Interview, 5 June 2003)

Interviewees were asked whether they felt there were any problems with calling people customers. All the respondents could identify limitations with using the language of customer in relation to service users, although most (21 of the 28) only raised limitations when prompted to do so by the interviewer. Responses fitted into one of two categories. For some respondents (12 of 28) the problem with customer language was that the council could never provide services in the range and quantity that a customer would want. In the case of social services support, for example, one respondent noted that he might have to tell an applicant for a carer:

> "What we're saying is there are actually other people who have greater difficulty and at this moment in time in terms of resource allocation what we're saying is you have to wait until you become worse." (Director of Policy, County Council, WM, Interview, 22 May 2003)

For a second category of respondent (16 of the 28) the customer language was limited because it did not capture the democratic role of the citizen. Councillors in particular (7 of the 9) were keen to emphasis the citizen dimension to being a local service user. One councillor raised concerns about the extent to which the language of customer "privatised" the relationship with local people, a concern shared by other councillors (Councillor, County Council, WM, Interview, 30 May 2003). These findings suggest that the councillors and officers interviewed did not see the citizen role as encompassed by the term customer. Officers appeared to see the role of customer as complementary to that of citizen, the former reflecting the role of service user, the latter indicating the democratic role of voter. Councillors were more likely to see the roles as incompatible, with a customer orientation eroding the democratic foundations of citizenship. This split between politicians and bureaucrats is perhaps unsurprising, since bureaucrats engage with the citizen primarily as service user, whereas councillors are more oriented towards the citizen as voter. Perhaps more surprising is that such a split is not evident at central government level, with politicians and civil servants equally keen to endorse a customer approach.

The evidence presented here suggests that the language of customer is utilised with central and local government, with implications for internal cultures and structures and for treatment of the service user. Five different conceptions of treating users as customers were identified from the local government interviews: payment-oriented, choice-oriented, personalised, access-oriented and courteous. It is possible to distil these five conceptions into three models of the customer, all of which interact differently with the citizen. The first model, based on payment and choice, can be seen as an economic conception, drawing its inspiration from economists" models of the consumer. Here services are improved through encouraging services to compete for providers and by channelling resources to the most successful. This model aims to make service providers more directly accountable to their users through market disciplines rather than relying on the blunt instrument of democratic accountability exercised through Parliament.

The second model, bringing in personalised treatment and improved user access, envisages a different driver of improvement. Here service providers seek to enhance the accessibility of services and to work with users to develop appropriate service provision. User choice may be a component of this model, but here it is not presumed to operate as a punitive mechanism and emphasis can be placed on service providers working cooperatively together to develop the best package for the user. Direct accountability to the service user does not preclude democratic accountability and collective voice in setting the parameters within which providers operate.

The third model prioritises courtesy and respect, without necessitating changes in services or provision. This approach resembles the model of responsive service offered by John Major's Citizen's Charter. The Charter used a series of rights and entitlements to specify universal standards. Unlike in the second model, users need not play a direct role in determining what those standards should be. The Charter model was designed to force service providers to be accountable to their users, but it offered compensation when services went wrong rather than scope to respond to user preferences in service design.

Of the three models, it is the second approach that offers the best hope of reconciling the customer with the active citizen. The citizen retains the personal autonomy and dignity that underpin citizenship, whilst not precluding collective decision-making over overall standards of service. It offers a way of combining direct accountability of provider to user with political tools of accountability. This model of customer care need not squeeze out active citizenship. However there do remain risks to bundling up the improvement of public services in a "customer service" package. If all the "positives" of the individual's relationship with

government are experienced as a customer, whilst all the "duties", such as paying taxes and voting, are linked to being a citizen, this threatens to dislocate the experience of paying for services from the experience of using them. The government needs to consider the merits of delivering good quality and responsive services to users as a condition of citizenship rather than as a concession to the customer.

April 2004

Memorandum by the Audit Commission for Local Authorities and the National Health Service in England and Wales (CVP 11)

EXECUTIVE SUMMARY

1. Choice is one of the ways in which people exercise control over their lives. In general, most people want as much choice as possible because it enables them to tailor goods and services to their specific wishes, and leads to higher satisfaction. People believe that more choice would help improve public services.

2. Users potentially have two types of choice:

2.1 Choice of service provider, for example of school or hospital, and

2.2 Choice of nature of service, ranging from alternative forms of social care to different ways of reporting crimes to the police.

3. Public service commissioners and providers exercise a third form of choice, in particular how to procure and provide services. Innovative partnerships can be a major driver of efficiency as well as an enabler of greater user choice.

4. The debate often focuses on the first form of user choice, which is relatively narrow. This can speed up service and redistribute demand, but requires surplus capacity, and information and support to help people choose. Besides potentially higher cost, it has limitations due to geography and raises issues of equity. There is scope for preferences about the nature of services to be increasingly met, because these may be more important to users than choice of provider and are not necessarily costly. People should be allowed to express preferences as of right, and public services should seek to be increasingly responsive to them.

5. e-government provides enormous opportunities to expand the scope for individuals to express preferences and tailor services to their wishes. In particular, it provides unparalleled opportunities to provide certain services 24 hours a day, 365 days a year, meaning they are always available at a time which suits users.

6. By their nature, public services involve significant choices on behalf of the wider community: about entitlements; obligations; taxes; charges; forms of provision; and value for money. Community choices therefore constrain individual choice in the wider public interest. There is always some degree of trade-off between individual and community choice.

7. There is a lack of clarity about how much choice individuals can exercise and about what. The extent of "consumer" choice in public services is itself a legitimate matter for political choice by communities—but a choice with profound implications about the nature and cost of public services. It is therefore important to understand the circumstances in which choice can operate as a force for improvement in public services, whilst also guarding against expanding choice into areas where it would undermine wider objectives, such as community benefit, social justice or value for money.

8. The cumulative effect of many individual choices will improve services incrementally if the provider organisations are aware of users' preferences and respond to them. There is no "big bang" solution to increasing choice; maximising choice should be an integral part of a culture of continual improvement.

9. It is a major challenge to create the conditions in which more choice can be exercised. It requires a different mindset, asking not "where could we provide choice?" but asking rather "where should we not provide choice?" because, for example, it is too costly.

10. There needs to be a systematic approach to expanding choice. It would be helpful to develop a generic framework identifying the necessary elements, providing a basis for community choices and providing a consistent basis for planning and monitoring the expansion of choice. It should have four elements:

10.1 Standards.

10.2 Equity.

10.3 Capacity.

10.4 Cost/value for money.

11. Regulators can play a vital role in bringing the forces for improvement together by providing challenge, supporting choice and sharing knowledge. To provide objective evidence about the performance of public services to local people, the Commission will report on:

11.1 The extent to which providers are actively seeking to maximise choice, and being responsive to it.

11.2 Whether users are given the full range of choices to which they are entitled, within any agreed community framework.

11.3 How effectively public bodies provide and disseminate relevant and timely information to help users make choices.

12. Overall, the Commission considers that seeking to increase the responsiveness of public services to people's preferences is likely to be the most productive way of increasing choice and user satisfaction whilst ensuring value for money. Doing so will require major behavioural change, rather than structural change, by introducing some of the underlying behaviours of the market economy into public services in order to understand and respond to users better.

The Audit Commission

1. The Audit Commission is an independent, non-departmental public body sponsored by the Deputy Prime Minister and the Secretaries of State for Health and Wales. Our mission is to be the driving force in the improvement of public services; we promote proper stewardship and governance and we help those responsible for public services to achieve better outcomes for citizens, with a focus on those people who need public services most.

2. This evidence draws on our work with local authorities, NHS bodies, police authorities and housing associations in England and Wales. The Committee's specific questions are addressed in Appendix 1. A summary of some of the issues about choice we have highlighted in our reports is at Appendix 2.

3. The Audit Commission's current work programme includes several studies that are relevant to developing choice, including a housing study assessing the costs and benefits of involving residents to be published June 2004[30]. Our Comprehensive Performance Assessments will include judgements on local authorities' performance in delivering choice, from 2005.

Choice

4. Choice is a complex concept. A practical working definition of choice is:

> The delegation to service users, of decision-making powers about where, when, by whom and how, public services are provided.

5. The definition of service users can include: clients; customers; carers; patients; residents; pupils; students; parents. It includes individuals, groups exercising collective choice (such as parents of pupils at one school, residents in one street or members of a particular care group), and society at large, which exercises choice on behalf of the whole community at local and national levels through the democratic process.

6. Choice is one of the ways in which people exercise control over their lives. In general, most people want as much choice as possible because it enables them to tailor goods and services to their specific wishes, and leads to higher satisfaction. A recent poll by YouGov for the Economist[31] showed that people believe that more choice would help improve public services:

> "What's more, they want choice not just for its' own sake—66% say choice of hospitals is very or fairly important to them, 76% of parents with children at state schools say the same—but also because they think it will make public services better. . . While 37% of respondents said (the health service) needed more money, 50% said what it needed most of all was reform to give patients more control over their treatment."

7. There are exceptions. For example, some people (especially the elderly) may choose to "trust the doctor" rather than weigh up complex options where there are difficult trade-offs in healthcare, and there is evidence to suggest that people have less wish to exercise individual choice where they judge basic public services (such as refuse collection) to be of a high quality.

8. However, in general, providing maximum choice is likely to lead to better services and more satisfied users. The principle should be to provide as much choice as possible to those most directly using public services, but with due allowance for the interests of other users and of society at large including considerations of value for money.

9. Choice increases both the effectiveness of services and users' satisfaction with them. Choice also helps compensate for imperfections—where services/products are poor, choice helps spread the blame (". . .after all, I chose it. . ."), though not always—especially if users believe they have been deliberately misled.

10. Users potentially have two types of choice:

10.1 Choice of service provider, for example of school or hospital, and

10.2 Choice of nature of service, ranging from alternative forms of social care to different ways of reporting crimes to the police.

[30] Audit Commission [2004] Housing: improving services through resident involvement (*this is the current working title).*

[31] *The Economist,* 7 April 2004.

11. The Commission believes that it is important that users can exercise choice to ensure that services are tailored to their particular needs and preferences. These choices may apply to institutions or particular individuals providing services, as well as to the extent, nature and timing of services. Public services should strive to be responsive to users' wishes; where they are, choice operates as a powerful force for improved quality and value for money.

12. Public services should therefore seek to maximise the scope for individual and collective choice where that is consistent with delivering wider social outcomes and value for money. Public service commissioners and providers exercise a third form of choice, in particular with whom to procure and provide services, which can be a major driver of efficiency as well as an enabler of greater user choice.

13. Whilst some progress has been made, the Commission believes there is scope for much more choice. At present the underlying systems and infrastructure do not encourage or facilitate choice in most public services. Increasing choice to a limited extent would be possible quickly, but it is not possible to deliver a significant increase without a concerted approach. Public services should adopt a mindset which puts users at the centre of their planning and delivery, incrementally increasing the extent of individual, collective and local community choice at every opportunity.

14. One word of caution. Choice should not be seen as a way of devolving responsibility for securing high quality services to the users, based on a sanction of moving business elsewhere. The prime responsibility for the quality of services rests with the providers, and one of the functions of regulators is to ensure that they fulfil it.

Two Forms of User Choice

15. The debate often focuses on the first form of user choice, which is relatively narrow—for example about schools or hospitals for elective surgery. This has some scope to speed up service or meet some specific user demands. Providing such choice more generally will require surplus capacity, which is inefficient, and good information and advice to help people exercise it. Besides potentially higher cost, it also has significant limitations as a driver of improvement. Geography is a significant constraint, because many public services need to be provided close to people's homes. There are also issues of equity; some groups of people will be better-placed for financial or other reasons to exercise such choices than others.

16. In fact individuals already exercise a wide variety of choices about the public services they use. For example people already choose to a greater or lesser extent:

16.1 Whether to take up entitlement to non-mandatory services.

16.2 About the extent of confidentiality and privacy.

16.3 Which services to have, where there are a number of reasonable alternative options available (eg different forms of treatment for the same condition). Such choices can be markedly enhanced, for example, by the use of vouchers to purchase a bespoke package of social care.

17. But there is scope for much more choice. Applying the principle that there should be the maximum choice for individuals, the key issue is to determine which aspects of a service should not be subject to choice and to create the infrastructure to enable people to exercise choice about the rest.

18. Choosing provider institutions can be helpful, for example to allow users to consider geography or reputation, but is also often an action of last resort. Parents are reluctant to change their children's school unless there are strong reasons to do so, and patients are unlikely to change GP if one appointment is inconvenient.

19. Having preferences met within a service, for example whether children attend religious ceremonies at school, the choice of a general or spinal anaesthetic for certain medical procedures and the choices available in childbirth, may be more important to users than the one-off choice of service provider. There is evidence to show that patients are more likely to complete a course of treatment if they have been involved in deciding what it should be, thereby increasing its effectiveness. Allowing people to express preferences should be a right, and public services should seek to be increasingly responsive to them.

20. e-government provides enormous opportunities to expand the scope for individuals to express preferences and tailor services to their wishes. The congestion charge in London provides users with a variety of methods of payment, and e-booking of housing repairs can improve both the efficiency of the service and customer satisfaction. With the spread of both the internet and digital TV, there is substantial opportunity to extend this further—for example:

20.1 e-booking appointments with all the various public agencies such as GPs, social workers, registrars and planning officials;

20.2 making processes easier such as reporting minor crimes, applying for parking permits or repeat prescriptions, making planning applications, selecting schools, paying bills and reporting nuisance such as fly-tipping; and

20.3 providing information to users which enables them to understand more about entitlements and progress about issues of direct concern to them personally.

21. In addition, e-government provides unparalleled opportunities to provide certain services 24 hours a day, 365 days a year, meaning they are always available at a time which suits users.

Choice in a Market Economy

22. The concept of consumer choice comes from the private sector. Choice works because those who use services or buy products generally also pay for their full costs. Choice is most effective as a driver of quality and value for money where consumers can choose from a number of competing suppliers. Suppliers have a strong incentive to be responsive, lest competitors put them out of business.

23. A key issue is that demand generates supply in a market economy. The direct link between using and paying for products ensures that adequate finance is available to meet demand. Although there may be a time lag, market forces tend to ensure supply exceeds demand at an economic price.

24. Despite the critical importance of choice in the private sector, the mechanisms operate imperfectly:

24.1 There is often a lack of information about the things that really matter such as reliability and life cycle costs.

24.2 Marketing affects judgement, and people often don't act rationally.

24.3 Shortages can be deliberately created, leading to waiting lists for desirable new cars or premium pricing for products.

24.4 Monopoly suppliers have no incentive to provide high quality, cost effective services.

25. As a result, consumers' ability to exercise choice is limited:

25.1 Private medical insurance costs are high, partly because users pay for services indirectly and partly because the complexity of the services makes it hard for non-experts to judge their value for money.

25.2 There have been scandals over financial services mis-selling, partly because customers have often lacked adequate information—or the skills to interpret it.

25.3 Water services are a monopoly for most people, and they cannot change supplier. Dissatisfaction with the railways is high.[32]

Choice in the Public Sector

26. There is rarely a direct link between how people use public services and how they pay for them. The National Health Service is free at the point of use, by statute; local authority leisure services may be subsidised to encourage healthy lifestyles; social housing is subsidised through housing benefit. Imperfect though it is in the private sector, the pure consumer model is therefore more limited in the public sector.

27. There are both differences and similarities between the way that choice operates in the public and private sectors. For example:

27.1 Community or collective choice is exercised over many aspects of the public sector which, in the private sector, would be left to individual choices (eg about service standards).

27.2 Though there are many similarities, there are also substantial differences in the way that the law and regulatory systems apply, partly to ensure that the interests of the tax-payer are protected.

27.3 The consumption of services represents a cost to tax-payers, but an opportunity for profit to private businesses. This is a fundamental difference between private and public sectors: one more hip operation by a private hospital means more profit, but one more hip operation by the NHS means more immediate cost to the public purse.

27.4 Individuals decide what to buy, when to buy, and whether to buy again, from the private sector. In the public sector, citizens may decide whether to exercise (or fight for) their entitlements; they may also choose whether to meet legal and moral obligations, for example in recycling waste.

27.5 The private sector controls demand by price when there is a shortage of supply; in the public sector, equity is an important factor.

28. In the public sector, where considerations of overall affordability impose constraints on public services, choice has a more limited role because:

28.1 There is not a direct link between price and services, so there is little incentive on the consumer to trade-off quantity/quality/cost when exercising choice.

[32] The railways are an example of how difficult it is to define public services. Although privatised, the public regards problems on the railways as the responsibility of the government. Many services funded from the public purse are actually provided by private sector companies, including prisons and housing benefit payments. And some "public" services are provided by not-for-profit organisations, such as charities and housing associations. In this paper "public service" has been taken to refer to those services which are largely funded through taxation and provided direct to members of the public.

28.2 Public services have to be rationed through decisions about entitlements, and may be rationed through unintended restrictions on access, such as waiting times.

28.3 There may be few real choices of provider institution available, especially in rural areas (and no choice over who is responsible for the roads).

28.4 People may not wish or be able to make choices for themselves, or may not feel capable of making sensible choices, especially if there is uncertainty over the consequences of alternatives.[33]

28.5 There are moral (and legal) obligations on users with which they do not always comply, for example maintaining a healthy lifestyle or fitting fire prevention equipment in homes. There is some controversy over whether entitlement to public services should vary depending on these choices, as in effect they do in the way that insurance operates in the private sector.

28.6 The availability of the necessary information is poor in respect of timeliness, relevance to possible (individual) choices, and accuracy, and it is often very hard to interpret.

28.7 There may be institutional and professional barriers to the exercise of choice by some user groups, such as people with learning disabilities, older people and children with disabilities.[34]

29. Part of the problem with the current debate about "choice" in public services is that there is a lack of clarity about how much choice individuals should exercise and about what. The extent of consumer choice in public services is itself a legitimate matter for political choice by communities—but a choice with profound implications about the nature and cost of public services which need to be better understood. This is not always the case. Our national report Trading Places[35] discussed the mismatch between pupil places and parental demand, and the high costs of surplus capacity in schools.

30. It is therefore important to understand the circumstances in which choice can operate as a force for improvement in public services, whilst also guarding against expanding choice into areas where it would undermine wider objectives, such as community benefit or social justice. Public services need a sophisticated understanding of what choices could be available, how "customers" can exercise them, and how competing priorities can be balanced. For example, people may be obliged to use public services in the wider interests of society (offenders, mental health problems; people with infectious diseases). Whilst they have to lose some freedoms, they remain citizens of society with rights and therefore some choices. It is important to enable them to exercise those choices.

31. Historically, however, public agencies have not set out to maximise the extent of choice available or sought to use it as a means for improving their services. In addition, there may be few incentives on the public services to be responsive. This needs to change.

Improving Public Services: Choice and Voice

32. There are many forces driving improvement in public services. Politicians establish standards and set entitlements. They allocate resources and set the framework for delivering services. Professionals, and others, provide those services and deal directly with the public, while managers are responsible for ensuring that standards are achieved and resources used well. The media inform the general public about those services and voters give power to the politicians. Advocate and representative groups lobby for improvements and they often represent collective wisdom, which informs and balances that of the professionals and the politicians as well as helping individual users exercise informed choice.

33. Those who can influence change—service users, voters, government, regulators, leaders, managers and professionals—share a common purpose. The more these forces for improvement are aligned, the better public services will become. Too often they operate in isolation, failing to establish a synergy for improvement and, at worst, working against each other.

34. Choice and voice are ways in which service users can influence improvement provided that the other parties are willing to respond. The cumulative effect of many choices will improve services incrementally provided that the provider organisations are aware of users' choices and respond to them. There is no "big bang" solution to increasing choice; maximising choice should be an integral part of a culture of continual improvement.

35. Evidence on the impact of choice on service improvement is limited. However, evaluation of the impact of direct payments schemes and choice-based lettings[36] strongly suggests that users perceive real improvements to their services. The common factors in the success of these two very different initiatives are that the exercise of choice solves problems which users identify themselves. When physically disabled users

[33] Patients judge doctors more on their "bedside manner" than on their clinical ability. They may need GPs to help them understand different treatment options and the consequences. Marshall, M and others [2000] Dying to Know: public release of information about quality of healthcare, Nuffield Trust.

[34] *See* Appendix 3 and Hasler F [2003] Clarifying the evidence on direct payments into practice, National Centre for Independent Living.

[35] Audit Commission [2002] Trading Places Update; [1996] The Supply and Allocation of School Places.

[36] Lent A and Arend, N "Making Choices" NLGN 2004.

are given the money to meet costs of their personal care, they are able to make arrangements to suit themselves, to get up and go to bed when they like rather than relying on a service which can only provide a standard level of care at times which suit the provider, not the user. In the words of one user:

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

Individual, Collective and Community Choice

36. In the private sector, individual choice tends to be restricted mostly by the ability of suppliers to meet consumers' wishes and consumers' ability to pay for them. Even so, society exercises some community choices to enable the market economy to operate fairly within the rule of law, and with due regard for safety and the needs of society. These community choices are enshrined through a variety of legal and regulatory mechanisms, such as the activities of the Financial Services Authority, rules about health and safety and pollution, and legal restrictions on the availability of alcohol to minimise the anti-social effects and costs of alcoholism.

37. But by their nature, public services involve more significant community choices: about entitlements; obligations; taxes; charges; forms of provision; and value for money. Community choices therefore constrain individual choice in the wider public interest. There is always some degree of trade-off between individual and community choice.

38. Groups can also exercise choice. For example, parents get involved with schools as governors, and residents of streets and neighbourhoods can be consulted or can work together to make choices about their local environment or prevent crime. These collective choices are similar to individual choices, and can operate only so far as the community framework permits.

39. Within the community framework, individual and collective choice can bring a range of benefits:

- 39.1 A pressure for better quality and individually tailored services, leading to improved outcomes and satisfaction.
- 39.2 A better balance between rights and responsibilities.
- 39.3 Increased engagement of citizens with their public services and a consequent increase of active citizenship.
- 39.4 Opportunities to develop more varied forms of service, for example—giving greater access to services 24/7, through e-government initiatives.

40. Uniform national or local standards do not need to preclude choice, but rather they set the boundaries within which it can be exercised. Paradoxically, as people's expectations and assertiveness grow, it may be necessary to limit their freedom of choice further. For example, it may be desirable to constrain individual choice in the interests of economies of scale or to maximise overall value for money, as seen in the way in which social care has been focussed on those most in need, and the guidance issued by the National Institute for Clinical Excellence. Our report on Primary Care Prescribing[37] highlighted the costs of prescribing drugs of limited clinical value or of over-prescription, often influenced by patient pressure.

41. Because community choices constrain the nature and extent of individual choices, as well as determine how public services will be paid for, people need to have the opportunity to influence them. Citizens exercise voice through voting at local and national elections, but also in a range of other ways, including though consultation,[38] lobbying and a variety of forms of "Active Citizenship". There is some evidence that the more people are actively involved in the process of procuring or providing services, the more they understand the difficulties, choices and trade-offs involved. Users of services have other ways to exercise voice, including direct discussions with providers and through complaints.

Choice and Value for Money

42. In some cases, there is a tension between providing choice and squeezing out surplus capacity on the grounds of efficiency—thereby reducing the scope for individuals to exercise choice[39/40]. This tension is inevitable. The theory of choice would suggest that expanding choice will act as a spur to improvement and up to a given point any associated cost would be worthwhile. The reality is that it is not possible to measure objectively where that point should be, and it is left to democratic processes to make the necessary judgements. However this has to be within the context that the public is increasingly demanding choice and comparing the extent to which they can choose in the private sector with that in the public.

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[37] Audit Commission [2003] Primary Care Prescribing: a bulletin for primary care trusts.

[38] Audit Commission [1999] Listen Up!

[39] Some "choices" do not require surplus capacity—for example to refuse aggressive treatment for cancer. Others do—for example to have choice over sending pupils to school.

[40] Audit Commission [2002] Trading Places Update; [1996] The Supply and Allocation of School Places—showed how the pressure to reduce surplus school places for reasons of efficiency also reduced options to choose schools.

43. Appendix 2 gives some examples of choice drawn from the Audit Commission's value for money studies.

44. Exercising choice can sometimes reduce the drain on the public purse. For example, people whose property has been stolen may prefer to report it by telephone than have to wait at home for one or more police officers to visit.[41] The growth of private education and healthcare are examples of individuals with money exercising choices, but so are the increasing availability of over the counter medicines and the introduction of pay-TV in hospitals[42]. It would be possible to extend this to provide better paid-for hotel services in NHS hospitals more generally as is the case in the private sector, including private en-suite accommodation, choice of food and the availability of alcohol (if medically approved).

45. Giving people more choice will not always be costly. The social care example quoted above did not involve an increase in cost. It would cost virtually nothing to allow people to choose different GPs when it suited them, for example to attend near the workplace in some circumstances and near home in others, rather than be confined to one practice, provided that the information and financial infrastructure was capable of supporting such choices. One NHS Trust has a long waiting list in gynaecology because they have the only female consultant in a wide area—a significant choice at no direct cost to the NHS.

Expanding Choice in the Public Sector

46. Whilst increasing choice will not always be expensive, it is a major challenge to create the conditions in which more choice can be exercised. The Commission believes that public organisations should set out to provide as much choice as possible to users and to groups of users. This requires a different mindset, asking not "where could we provide choice?" but asking rather "where can we not provide choice?"

47. Expanding choice in the public sector carries a number of risks, including:

- 47.1 Increased costs caused by the loss of economies of scale and wasted resources from unused surplus capacity.
- 47.2 The danger of raising citizens' expectations, which cannot be met.
- 47.3 Damage to the interests of the wider community, for example by increasing exclusion of those least able to exercise choice or by exacerbating the impact of "failing" public services.
- 47.4 Variation in the availability and quality of public services which is not justified by local circumstances ("postcode" variations), and brings risks to the maintenance of high national standards, transparency and accountability.

48. There can also be barriers to expanding choice. For example, if a small school is popular, there is little incentive for it to expand even though many parents may wish their children to be educated there. In fact there may well be disincentives to expand, particularly to avoid the risk of undermining a successful formula.[43] And providing choice may require professionals to change their ways of working, for example to provide outpatient appointments in community settings, with personal disadvantages.

49. Expanding choice is therefore not straightforward. Partly it requires a change of mindset away from providing uniform services (to ensure a crude form of equity) to allowing services to be tailored to meet individual's preferences. But it will also require services to be redesigned to enable more choice to be exercised. There are three main issues:

- 49.1 When is it desirable and appropriate to offer individuals choice about the services they receive? This requires community choices to be made, and for them to be made explicit.
- 49.2 What infrastructure and systems are needed to enable informed choices to be made and to ensure equity, especially for those least able to exercise choice themselves?
- 49.3 What incentives would work to make service providers responsive?

50. Building an enabling infrastructure will take time. It should include:

- 50.1 The systems needed to support choice, for example—facilities for e-booking appointments.
- 50.2 A substantial increase in timely and relevant information.
- 50.3 Access to independent advice and advocacy services when required, and expert support to exercise choice where necessary.
- 50.4 Financial management information systems that can accommodate service options.
- 50.5 Staffing, appropriate to the choices on offer.
- 50.6 Staff training and development that takes account of the commitment to promote user choice.
- 50.7 Incentives to encourage public sector organisations to increase user choices.

[41] Audit Commission [1993] Helping with Enquiries: tackling crime effectively.

[42] Pay-TV is an interesting case where providing more individual choice can have negative side-effects. Patients have complained that they cannot turn off the continual advertising on pay-TV screens, meaning that one "no-choice" option has been replaced with another.

[43] Audit Commission [2002] Trading Places Update; [1996] The Supply and Allocation of School Places.

51. There needs to be a systematic approach to expanding choice. It would be helpful to develop a generic framework for helping public services do so based on four elements:

51.1 Standards. This element of the framework would cover minimum standards for service quality; governance; accountability; economy/efficiency/effectiveness; and professional standards.

51.2 Equity. The equity element of the framework would cover: equality of access; services meeting diverse needs; accessible information; support to exercise choice and advocacy.

51.3 Capacity. This element of the framework would cover prioritisation; the capacity of services to expand and the willingness to do so; unused and under-used capacity, rationing/control; and contestability—ie new providers; skill mix; incentives and barriers.

51.4 Cost/value for money. The framework would need to include an assessment of where there are (and are not) costs associated with choice (and the costs of not providing choice); an understanding of value for money overall—balancing any increased short-term and/or long-term costs against improved outcomes; potential savings and the scope for charging for additional choices.

52. Such a framework would help identify the different elements which need to be in place for choices to be real, as well as providing a basis for exercising the community choices which constrain individual freedoms. It could also provide a consistent basis for planning and monitoring the expansion of choice.

The Audit Commission Contribution

53. Regulators can play a vital role in bringing the forces for improvement together. We see our role, tailored in each sector, to work in partnership with other regulators, as:

53.1 Measuring performance—providing the baseline against which improvement can be assessed and independent verification of the extent to which it is happening.

53.2 Providing challenge—both locally through audit and inspection activities and nationally through reports drawing attention to issues of wider concern.

53.3 Supporting choice—assisting service users and taxpayers to provide their own challenge and exercise choice where it is available to them, by promoting active and informed citizenship through the dissemination of easily accessible information about the comparative performance of local services and by supporting better public reporting by bodies subject to audit.

53.4 Sharing knowledge—working with others to spread good practice, both within and across the sectors we work with, and whether drawn from our own work or from international experience and benchmarks.

53.5 Supporting public service managers—through seminars, workshops, self-assessment tools and in other ways, including studies undertaken at the request of audited bodies under section 35 of the Audit Commission Act 1998.

54. In undertaking its work, the Commission will consider and report on:

54.1 The extent to which providers are actively seeking to maximise choice, and being responsive to it.

54.2 Whether users are given the full range of choices to which they are entitled, within any agreed community framework.

54.3 How effectively public bodies provide and disseminate relevant and timely information.

55. This approach will provide objective evidence which will also help local people exercise voice more effectively, especially where providers are not responsive.

56. Our Strategic Plan 2004–07[44] describes how we intend to contribute to improved public services, seeking to encourage public bodies to expand choice where appropriate as described in this paper.

Conclusion

57. The public wants more choice in public services as well as in its dealings with the private sector. Choice has a part to play in public service delivery, albeit in a different way from the private sector. It can be a significant driver of improvement and it can help to increase user satisfaction with public services.

58. We have stressed the importance of being clear about, and of communicating clearly about the extent and scope of the available choices. Providers must ensure that they have adequate resources and provide relevant and timely information that informs users' choices. They need to be responsive to users' choices and preferences, actively seeking to provide choice whenever feasible. They need to be creative in the choices they make about how they commission and procure services to increase choice. It is also important for them to have a mechanism whereby improvements are universal, recognising that many citizens will not be able to, or will not choose to exercise choice. In essence, the public sector needs to be able to respond quickly and flexibly, to changing choices—traditionally, it has found this difficult to do.

[44] The Strategic Plan can be found on our website at www.audit-commission.gov.uk.

59. Overall, the Commission considers that seeking to increase the responsiveness of public services to people's preferences is likely to be the most productive way of increasing choice and user satisfaction whilst ensuring value for money. Doing so will require major behavioural change, rather than structural change, by introducing some of the underlying behaviours of the market economy into public service in order to understand and respond to users better.

APPENDIX 1

ANSWERS TO THE COMMITTEE'S SPECIFIC QUESTIONS

Defining What Choice Means in the Public Sector

1. *How is choice in public services to be defined?*

Choice is a complex concept. A practical working definition of choice is:

The delegation to service users, of decision-making powers about where, when, by whom and how, public services are provided.

The definition of service users can include: clients; customers; carers; patients; residents; pupils; students; parents. It includes individuals, groups exercising collective choice (such as parents of pupils at one school, residents in one street or members of a particular care group), and society at large, which exercises community choice on a wider scale at local and national levels through the democratic process.

"Public Services" are not clearly defined. The public still has a tendency to consider railways to be a public service even though privately owned, and many publicly-funded services are provided by private businesses or non-for profit organisations.

2. *Will the nature of choice vary depending on the type of provision or service?*

Yes, inevitably. Some services can only be provided in one geographic locality (street sweeping) where as others can be provided elsewhere (elective surgery). Many services lend themselves to a variety of choice about the precise nature of services to be provided (maternity, social care).

3. *Is "choice" simply a euphemism for competition and market mechanisms?*

No, competition, like choice, is one of the elements that make markets work effectively.

The concept of consumer choice comes from the private sector. Generally, in the private sector, individuals exercise choice through decisions on whether or not to spend their own money. If products and services are not seen as competitive, they are unlikely to succeed, and thus competition in the private sector drives improved quality and value for money. Choice acts as a powerful spur for quality and value for money.

It is possible to transfer some aspects of choice as it is understood in the private sector, to the public sector. However, the nature of the public sector makes it impossible to transfer all elements of private sector choice. The key issue for government is identifying how best to develop choice as a force for improving public services.

The choice exercised by a few citizens can create a more general pressure to improve service delivery, although only in some aspects.[45]

The Concept of Customers of Public Services

4. *Is it possible to have customers of public services as well as active citizens and democratic accountability or are they mutually exclusive?*

The concepts are not mutually exclusive. Active citizens will be a subset of "customers" of public services. Democratic accountability is the mechanism by which citizens can hold those responsible for the nature, scope and quality of public services to account.

[45] Audit Commission [2003] Trust in the Public Sector, MORI report for the Audit Commission.

5. *Is it necessary to devise a more precise and generally acceptable definition of who the user or customer for each service is? For example is it the pupil who is the user of the school system when it is the parent who exercises the choice?*

There are multiple users (or "customers") for many public services. Pupils and parents are customers for education, but so is society at large which needs a skilled workforce.

Public services need to understand the needs of all the customers for their services and balance their interests appropriately.

6. *Is it possible to identify a customer for the entire range of government functions or is it limited to public facing activities as envisaged, for example, in the Next Steps approach of the late 1980s?*

No, it is difficult to apply the concept of the "customer" to some government functions. For example, who is the customer for defence? What choices do they have? Voting may change governments, without changing defence priorities.

See also answer to Q5 above.

Mechanisms for Expressing Choice

7. *Are targets and league tables, customer surveys and complaints systems sufficient for ensuring adequate responsiveness to consumer preferences?*

No—other mechanisms are also required.

Targets and league tables perform different functions from those of customer surveys and complaints systems. They all have a part to play in improving public services. Currently, however, these elements do not operate as one integrated system for ensuring quality and responsiveness in public services.

The published products generally have little relevance or applicability to individual consumers, except where it is possible to translate them into timely and relevant information that will help the consumer in making choices.

Most league tables are produced at a high level of aggregation. Aggregated scores, such as the NHS star ratings, have little relevance for individual users.[46] Education scores are highly controversial, but they do have some credibility with the general public and relevance for parents.

Provided they are well-designed, customer surveys and other consultations can be important ways of gathering citizen and customer views. Currently, few public sector organisations make good use of such information to help them improve their services, or to increase choice.

Targets can be used to reflect collective choices (arguably, the waiting times target is a collective choice for the NHS. Also, it would help if the targets and league tables reinforced customer responsiveness: A & E is not really a "choice" service, but the 4 hour wait target could be better developed as a customer satisfaction survey and reflected in the targets and league tables. Thus, how one responded to customer preferences where choice wasn't really an option, would become important.

Complaints are a vital source of information, but few public sector organisations use them well. It will be interesting to see if including an intermediate complaints function in the new Healthcare Commission helps encourage better use of this source of intelligence in the NHS.

There is a danger in using the volume of complaints as a measure of performance, rather than as a source of information about performance. The aim should be to encourage feedback, rather than to stifle it.

8. *Is contestability a further requirement to make choice fully responsive? If so, to what degree?*

Where new suppliers are likely to enter a market, the threat of potential entry constrains the existing suppliers and prevents them from raising prices—in other words the market is "contestable". In theory, in contestable markets, existing suppliers charge low prices, even if they have very high market shares.

Attempts to introduce competition to the public sector have sometimes failed because of the absence of viable alternatives to existing provision (as experienced in local government during Compulsory Competitive Tendering). This suggests that in order to promote a competitive environment and secure the cost and choice benefits afforded by competition, a necessary first step would be to promote contestability; even where, for the time being, other constraints (eg statute) prevent full competition from operating; ie we must create the conditions for competition. But this then raises questions about the amount of surplus capacity that the market can bear.[47]

[46] Audit Commission [2003] Achieving the NHS Plan.

[47] Koen, Vincent [2000] Public Expenditure Reform: the Health Care Sector in the UK, OECD: Economics Department Working Papers No.256.

9. *Can individual choice, collective choice and choice on behalf of the citizen (by Government or Local Authorities for example) operate successfully alongside each other?*

Yes, but it is important to be clear who exercises choice over what.

In the private sector, individual choice tends to be restricted mostly by the ability of suppliers to meet consumers' wishes and by consumers' ability to pay for them. Even so, society exercises some community choices to enable the market economy to operate. These community choices are enshrined through a variety of legal and regulatory mechanisms such as the activities of the Financial Services Authority; rules about pollution; and legal restrictions on the availability of alcohol, in order to minimise the anti-social effects and the costs of alcoholism.

By their nature, public services involve more significant community choices: about entitlements; obligations; taxes; charges; forms of provision; and value for money. Community choices therefore constrain individual choice in the wider public interest. There is always some degree of trade off between the extent of individual and of collective choice. It may be desirable to constrain individual choice in the interests of economies of scale or to maximise overall value for money, as seen in the guidance issued by the National Institute for Clinical Excellence. Our report on Primary Care Prescribing[48] highlighted the costs of prescribing drugs of limited clinical value or of over-prescription, often influenced by patient pressure.

We need a more sophisticated understanding of the actors exercising choice. At the individual level, people exercise choice both on their own behalf and on behalf of others for whom they have responsibility or duties of care, for example parents on behalf of children. At the collective level there are, for example:

- Communities of special interest, eg RNID campaign for digital hearing aids.
- Communities of diverse but related interests, eg local businesses in business improvement districts opting and paying for more frequent refuse collection.
- Communities based around geography, eg residents in a particular street campaigning for the introduction (or removal) of traffic calming measures.

10. *Are all these forms of choice equally effective in ensuring (a) efficiency and responsiveness and (b) equity and fairness?*

No, they have different roles. Within a framework created collectively, individual choice can bring a range of benefits:

A pressure for better quality and individually tailored services, leading to improved outcomes and satisfaction;

A better balance between rights and responsibilities;

Increased engagement of citizens with their public services and a consequent increase of active citizenship;

Opportunities to develop more varied forms of service, for example—giving greater access to services 24/7, through e-government initiatives.

Individual choices may work against efficiency or equity; and therefore society may need to constrain individual choice through community choice in a ballot box. Because collective choices constrain the nature and extent of individual choices, as well as determine how public services will be paid for, people need to have the opportunity to influence them. Citizens exercise voice through voting at local and national elections, and in a range of other ways, including though consultation,[49] lobbying and a variety of forms of "Active Citizenship". There is some evidence that the more people are actively involved in the process of procuring or providing services, the more they understand the difficulties, choices and trade-offs involved. Users of services have other ways to exercise voice, including direct discussions with providers and through complaints.

Choice and Equity

11. *Is there a generally understood definition of what equity means in respect of public services?*

No; the term means different things to different people. There is confusion around the use of the terms "equity", "equality" and "equality of opportunity".[50] Most public sector workers would understand what "equality" means in terms of fair access to employment; some understand the implications for service delivery.

[48] Audit Commission [2003] Primary Care Prescribing: a bulletin for primary care trusts.
[49] Audit Commission [1999] Listen Up!
[50] Audit Commission [2002] Equality and Diversity.

Does equity currently exist in public service provision? If not who have been the main beneficiaries and why?

No, equity does not truly exist in public service provision at present. "Equity" is not absolute; it can only ever exist in part.[51] At present, there is a "postcode lottery" for some services, where some providers in one geographical area operate differently from those in other areas, perhaps due to different resources. A crude, profit-driven market will tend to militate against equity, for example in the provision of affordable and reliable public transport in rural areas. Also, those people who are better resourced (in terms of their education, income, ability to choose etc), are often able to obtain better services and outcomes. The key issue here is how best to reduce the inequalities.

12. *Must there necessarily be losers in a system involving choice and contestability?*

No, there should be no "losers", always provided that the system contains appropriate safeguards. There will, however, be greater variety of services provided if they are better tailored to the needs of individuals. This will require a tolerance of variation. Some variations will be chosen by communities (local priorities) and some by individual preferences (to tailor services to their needs).

See paragraphs 33–38 above.

A crude, profit-driven market will tend to militate against equity, for example in the provision of affordable and reliable public transport in rural areas.

The main issue for providers is what happens to poor performers, who need support to improve. The Audit Commission has been keen to share the learning from its CPA work as quickly as possible.[52]

13. *How can a choice-based provision of public services avoid providers "cream-skimming" the less difficult or resource intensive users of the service?*

There is a need for minimum standards and entitlements and mechanisms to ensure they are provided. There is also a need to provide some form of help for those who are less able to exercise choice by themselves.

Information for Users

14. *To what degree is the ability to evaluate different providers necessary for consumer choice?*

The ability to do this is critical. But that ability is absolutely dependant upon the provision of robust, timely and accessible information. It should be local; timely appropriate to the options available; and sufficiently detailed. Studies show that this is rarely the case in public services.

This also begs the question of what is meant by "different providers"?—Different hospitals? Or different doctors in one hospital? This can make a vital difference to individual patients, but enabling them to make informed choices where service delivery touches on professional competence, is very difficult. It may be very hard for public service users to make sensible choices, especially if there is uncertainty over the consequences of different choices.[53]

It should be noted that the possibility of having one's preferences met within a service may be just as important to the user as a choice of service provider, for example, the choice of a general or spinal anaesthetic for certain medical procedures and the choices available in childbirth.

15. *How should those users less able to make informed choices because of their income or situation be empowered to do so? What form should the provision of information take?*

There may be institutional and professional barriers to the exercise of choice by some user groups, such as people with learning disabilities, older people and children with disabilities.[54]

There is a need to empower such people. At its most basic level this could be providing assistance by way of translation into a minority ethnic language, but other situations may require providing the individual with advice on different options or even advocacy in decision making. Their situation is not an adequate reason for failing to provide as much choice as possible; rather it is a pressing reason to provide help, so that they can exercise their right to choose. Question 14 outlines the need for good information—this will support not only the individual but also their advisors and advocates.

[51] Holmes, C [2003] Housing, equality and choice, Institute of Public Policy Research.

[52] Audit Commission [2002] A picture of performance: early lessons from Comprehensive Performance Assessment.

[53] Patients judge doctors more on their "bedside manner" than on their clinical ability. They may need GPs to help them understand options and the consequences. Marshall, M. and others [2000]; Dying to Know: public release of information about quality of healthcare, Nuffield Trust.

[54] See Appendix 3 and Hasler F [2003] Clarifying the evidence on direct payments into practice, National Centre for Independent Living.

16. *How is satisfaction with and the performance of services to be measured, by whom and how is that information to be made available?*

Measuring customer satisfaction should be a function of service managers. At their best, service providers actively seek feedback from customers and other stakeholders and use this information to inform decision making and thereby drive continuous improvement. Regulators have an important role to play in validating this information and providing reassurance to a variety of stakeholders about its reliability.

Comparing public services adds value and can partly compensate for the lack of competition in most public services. Information about user satisfaction should be comparable, to show users the performance of various service providers.

Voice and Public Services

17. *What mechanisms (complaints, feedback) exist or should be created for exerting influence on providers? Are they available to all?*

A number of mechanisms exist and are used to a greater or lesser degree, depending upon the type of service:[55]

Consultation;

Scrutiny;

Performance management from top management;

Peer pressure;

Pressure groups of service users;

Democracy.

The Audit Commission report *Listen Up!* contains a wealth of advice for public sector organisations on effective consultation. The key issue is whether provider organisations respond to the news they receive.

18. *Does the complaint system operate effectively and equitably in the public sector? If not what should be done to improve this?*

No because complaints systems operate in favour of the most articulate and resourceful. In health services, the introduction of Patient Advice and Liaison Services (PALs) is helping to resolve problems for some of the people who would not naturally be inclined to pursue a complaint to achieve a resolution.

19. *Is decentralised decision making and "direct user engagement" an expression of "new localism" or will it lead back to a Victorian-style future of education, health or sanitation boards of the local great and good?*

There is a need to achieve a judicious balance between loose/tight, between the national framework and local flexibility. Local services for local people should mean a greater variety of services provided that are better tailored to the needs of individuals.

It is important to recognise the democratic role of local authorities here. In addition to national priorities, local Councils will have included local and regional priorities in their performance plans, following consultation with residents on local spending priorities and charges for services, in advance of setting the annual council tax.[56]

The new Foundation Trusts will provide an interesting experiment with a different form of accountability and engagement with the local population. It is too early to judge the level of interest in this opportunity for people to stand as representatives for the trust boards. However, there is a risk that in creating a multiplicity of arrangements, there is a loss of co-ordination and costs may rise as economies of scale are lost.

Devolution and Diversity

20. *At what levels can choice and voice operate within public service provision? Do they reinforce greater localism and devolution?*

Choice and voice can operate at local, regional and national levels within public sector provision; they can reinforce greater localism and devolution.

[55] Audit Commission [1999] Listen Up!

[56] Audit Commission [2003] Council tax increases 2003/04 Why were they so high?

21. *Is diversity a prerequisite for choice? If so does diversity refer to good and bad performers or to the requirement for some unique selling point from the provider such as faith or specialist schools?*

Diversity of requirements means that there is a need for diversity in provision, before choice can be available.

Choice is simply one mechanism for helping to ensure that there is the right provision to meet citizens' diverse needs.

22. *Does choice risk reinforcing the so-called "postcode lottery"?*

No. The term "postcode lottery" refers to current differences in basic entitlements and the quality of provision, across the UK. Some degree of local variation is inevitable—and, if intentional, it can be desirable (for example to reflect particular local circumstances). Community and individual choice can provide legitimate reasons for local variations.

There is a problem where variability is unintended or where it undermines equity, for example differences in the availability of particular prescription drugs or treatments, between different health regions of England.

Choice and the Public Good

23. *Can the consumer be "sovereign" in the public services? If not, why not?*

No, because of availability of services, budgetary constraints, the need to consider the interests of the wider community, etc. However, it is possible to create cultures and systems which enable users to be "queens" rather the "pawns" in the provision of public services.[57] This could be done by empowering users with information on service quality and the availability of options, training staff to provide a supportive service for users, exercising choice and introducing financial incentives for services, which ensure that money follows users.

The consumer could and should have a great deal more choice than at present, in terms of what they have, when they have it, and added services. For example, access to routine GP appointments outside of normal working hours and at weekends, as well as for emergencies; more options on waste collections for recycling; levels of community policing.

24. *Is there a risk that a consumerist approach to public services will undermine the public service ethos?*

There is no reason why it should; the public service ethos should motivate staff to provide high quality services. Giving people as much choice as possible is one element of quality service.

25. *Does the creation of individual consumers for public services put social cohesion and the idea of the public good at risk? If so what alternatives are there to the consumer choice agenda for public service reform?*

This should not be an issue if the choice is exercised within a clear framework which ensures equity and supports social cohesion. For example, people may be obliged to use public services in the wider interests of society (offenders, mental health problems; people with infectious diseases). Whilst they have to lose some freedoms, they remain citizens of society with rights and therefore some choices. It is important to enable them to exercise those choices.

Capacity in the Public Services

26. *Will the extension of choice create unmanageable demands on the capacity of public services to provide? If so is some degree of excess capacity necessary for choice to operate effectively?*

Public services will need some excess capacity in order for some (but not all) choices to be meaningful. There is a need to balance choice and efficiency.[58] Politicians however, at both local and national level will need to take a view about the quantum of surplus capacity that can be sustained and if it is affordable, recognising that without at least some surplus, some choices may be denied. Choice can also help to manage or divert demand, for example—GPs exercise a gatekeeper role in the health service, for example in their prescribing decisions.[59] In some cases exercising choice can reduce the drain on the public purse. For example, people whose property has been stolen may prefer to report it by telephone than have to wait at home for one or more police officers to visit.[60]

[57] Le Grand, J [2004] Motivation, Agency and Public Policy: of Knights, Knaves, Pawns and Kings.
[58] Audit Commission [2002] Trading Places Update; [1996] The Supply and Allocation of School Places.
[59] Audit Commission [2003] Primary care prescribing.
[60] Audit Commission [1993] Helping with Enquiries: tackling crime effectively.

27. *What are the cost implications of this? Should it lead to an extension of Private Finance Initiatives?*

The extension of choice does not necessarily imply the need for substantial new capital investment. It is often the availability of choice in relatively simple matters that influences user perception of service delivery and the level of satisfaction with public services.

Giving people more choice will not always be costly. It would cost virtually nothing to allow people to choose different GPs when it suited them, for example to attend near the workplace in some circumstances and near home in others, rather than be confined to one practice; provided that the information and financial infrastructure was capable of supporting such choices. However, it is a major challenge to create the conditions in which citizens can exercise more choice.

In some instances, there is a risk of increased costs caused by the loss of economies of scale[61] or the diversion of resources to supporting unused surplus capacity.

PFI is a mechanism for funding public services; it does not have a specific impact on choice.

28. *Are user charges an inevitable outcome of greater choice? Might user charges help widen choice?*

Charges play a part in expanding choice and rationing demand. It may be useful to extend choice beyond a basic minimum. In some instances people's willingness to pay can be an indicator of the real value that they place on a particular choice.[62]

The growth of private education and healthcare are examples of individuals with money exercising choices at local level. Other examples are: the increasing availability of over the counter medicines; car parking; music lessons in schools; arrangements between local authorities and their residents, to share the cost of additional street cleaning at the residents' request and the introduction of pay-TV in hospitals. The latter is an interesting case where providing more individual choice can have negative side-effects. Patients have complained that they cannot turn off the continual advertising on pay-TV screens even if they choose not to use the facilities; TV in wards can be intrusive and distressing for seriously ill patients and their relatives.

There is scope to use changes more creatively. In private hospitals, patients pay for better hotel services, such as meals and alcohol (if medically acceptable). Since paying for car parking and TV is common in the NHS, why not extend the choice and charge for them?

29. *Would enforcing equity in a co-funded, choice-driven system imply a proliferation of regulators on the model of the Office of Fair Access for the universities?*

Equity in service delivery is as much a matter of winning hearts and minds as it is of legislation and service standards. Therefore, it may prove difficult to attempt to enforce equity through regulation. It is too early to say whether the OfFA will prove effective.

The Audit Commission is committed to strategic regulation that is proportionate to risk. Government may find this model of regulation useful here.

Raising Standards

30. *What is the nature of choice within a framework of uniform standards?*

There need to be uniform minimum standards for service delivery which ensure an acceptable level of service and safety.

Clearly, these standards cannot cover everything comprehensively; they cannot take account of individual circumstances and preferences, for example, whether someone is willing and able to travel to a hospital outside their own region, in order to reduce the waiting time for an operation.

Uniform standards do not have to preclude choice—they merely specify the choices that can be offered to users.

31. *How can an individual's choice enhance national standards and accountability?*

People define what they value by the way that they vote. However, "public value" also includes intangibles such as perceptions of fairness, choices that will affect for future generations, etc. These voting choices are then translated into expectations of basic entitlement; and government sometimes further translates these into national minimum standards against which public sector providers may be held to account.

[61] *Financial Times* 16 February 2004 Feature on the (Gershon) Efficiency Review: the leaked report.
[62] Audit Commission [1999] The price is right: charges for council services.

EVIDENCE BASE

32. *Is there already sufficient evidence, research and experience to judge the effect of greater choice on equity in public services?*

Research evidence is available, including studies by Perri 6;[63] the Local Government Association;[64] The New Local Government Network;[65] and The European Foundation for the Improvement of Living and Working Conditions.[66]

There has been relatively little work looking at the issue of choice across services, or exploring the implications for collective decision-making processes. Most policy analysis and evaluation has been service specific, for example—Parental choice in schools; Patient choice in the NHS; Choice based lettings in social housing; and Choice in social care.

There is research in progress, which may have a bearing on equity, including an Audit Commission study on choice;[67] the London Patient Choice Project;[68] The Open University study;[69] and the Social Market Foundation study.[70]

33. *Does the functioning so far of parental and patient choice support the argument that it promotes equity?*

It is possible to find champions for each side of the argument. Several academics[71,72,73] and many of the leading think tanks in the policy community have published material that deals with the arguments for and against choice. For example the Fabian Society;[74] The Kings' Fund;[75,76] and the Social Market Foundation.[77]

34. *Are there lessons that can be learned from other countries and if so are they readily applicable here?*

Over the last 25 years there has been a strong focus on public sector reform in Australia, with improvements in service delivery being an important part of this reform. Drivers of improved service delivery include a better informed, better educated and more demanding public, and improvements in technology, which have increased the capacity to provide more immediate and responsive services. Competitive pressures have also demanded increased productivity, and facilitated higher quality and effectiveness. The increased focus on improving service delivery is reflected in the approaches of a number of agencies.

One example is the Job Network, a system of non-government organisations, both profit and non-profit, which have won tenders to provide employment-related services to unemployed people on behalf of DEWR. The Job Network seeks to tailor services more to individual needs, and provides an element of choice for individuals over their service provider. Evaluations of the Network have concluded that the new system is substantially more cost-effective than the former employment services arrangements, and that the quality of service has improved.

Another example is the Australian User Choice policy. This is a national policy governing the flow of public funds to training providers that works in conjunction with the New Apprenticeships System. The objective of the User Choice policy is to make the vocational education and training system more responsive to the needs of industry and employers and therefore of more benefit to people receiving training. In principle, the flow of public funds to individual training organisations reflects the client's choice of provider. The User Choice policy was endorsed by the Ministers for vocational education and training in May 1997 and amended in November 2000.

63 Perri 6 [2002] Giving consumers of British public services more choice: what can be learned from recent history? Institute for Applied Health and Social Policy, King's College, London. http://www.hsmc.bham.ac.uk/staff/staffdetails/6p/pdfs/P6%20Consumer%20choice%20in%20British%20public%20services.pdf

64 Local Government Association [2004] Enabling Choice: research on choice in public services.

65 New Local Government Network Making choices.

66 European Foundation for the Improvement of Living and Working Conditions [2000]. Social Public Services: Quality of Working Life and Quality of Service: Summary of the Danish National Report.

67 Audit Commission research in progress 2004: study on choice in public services.

68 http://www.london.nhs.uk/patientchoice/overview.htm.

69 Open University: research in progress 2004: Creating Citizen-consumers: changing relationships and identifications.

70 Social Market Foundation: research in progress 2004 Choice and Voice in Public Services.

71 Gorad and Sitz [1998a] The more things change . . . the missing impact of marketization, British Journal of the Sociology of Education, Vol.19, p 363 to 367.

72 Bradley, S and Taylor, J [2002] The report card on competition in schools, Adam Smith Institute.

73 Brigham, H. [2000] School choice and social justice, OUP.

74 Levett, Roger and others [2003] "A better choice of choice: quality of life, consumption and economic growth", Fabian Society.

75 King's Fund [2003] Can market forces be used for good? Shaping the new NHS.

76 King's Fund [2003] What is the Real Cost of More Patient Choice.

77 Pollard, Stephen and Raymond, Katherine [1999] A Question of Choice: Public Priorities for Health Care.

Under the User Choice policy, the "client" is the employer and employee identified in the training contract, acting jointly. This definition reinforces the ideal that vocational education should benefit both the people being trained and the companies that employ them. Each state and territory is responsible for implementing User Choice in its jurisdiction. The User Choice policy sets out guidelines that the states and territories follow.

APPENDIX 2

ISSUES FROM AUDIT COMMISSION REPORTS ON CHOICE AND VFM

1. Many of our national studies note the tensions between users' desire for choice and the level of resources available in the service. There is a need to balance the individual's desire for choice and the public sector's managerial accountability for securing overall value for money, for citizens and taxpayers. The examples below illustrate the issues.

Education

Special Educational Needs: a mainstream issue [published November 2002]

2. One in five children—a total of 1.9 million—in England and Wales are considered by their school to have special educational needs (SEN). This is the second and final report from an Audit Commission research project on children with SEN. It looks at how well our system of education is serving children with SEN.

3. All parents have a right to express a preference about which school their child should attend and schools are legally required to admit a child if named in their statement. However, the parents that we met tended to feel that they had little choice over which school their child could attend for one of two reasons:

3.1 There was no school or early years setting locally which they considered appropriate;

3.2 They felt that some schools and early years settings did not want their child to attend.

Health Care

Primary Care Prescribing [published March 2003]

4. This Bulletin presents the findings of auditor's local work on prescribing in primary care, carried out in over 120 primary care trusts (PCTs) in England. It provides practical guidance for PCT board members, chief executives, Directors of Finance, prescribing advisers and GP leads, to help them get the most benefit for patients from prescribing budgets.

5. Primary care prescribing is costly and these costs are rising rapidly. PCTs are finding it very difficult to fund the growth in prescribing spending, and most are facing a significant funding gap. Good management of prescribing is about more than containing costs. It is about improving the quality of prescribing by putting in place systems to ensure that spending on drugs is targeted at patients who will benefit from the treatment, and that the most cost-effective treatment option is used without compromising patient care.

6. The Audit Commission has developed a national prescribing savings database, which estimates potential savings in a number of categories, for example, reducing spending on drugs considered to have limited clinical value, and ensuring that certain drugs known to be often over-prescribed, for example antibiotics and ulcer healing drugs, are only given where clinically necessary. The study estimated that over £130 million (2.3% of the drugs bill) nationally could be saved in the categories of drugs targeted in this database, over the medium term.

7. A key challenge for PCTs is to effectively influence the prescribers. Many factors influence a GP's decision on what to prescribe to a patient, including higher patient awareness of new treatments, and increased expectations. We said in our report:

> *. . . Where external influences, such as patient expectations or pressure from pharmaceutical company representatives, are counter to the goals of the PCT, a strong line should be taken. This could involve:*
>
> *. . . giving GPs advice on how to deal with the pressure from patients . . .*

8. We recognise that, in taking a value for money stance, our advice to PCTs may affect patients' ability to persuade their GP on the choice of medication, or on their preferred brand.

Fully Equipped: the Provision of Equipment to Older or Disabled People by the NHS and Social Services in England and Wales [published March 2000]

9. Older people need an environment that they can shape, and where they can thrive and live life to the full for as long as possible. The challenge for communities and councils is to be inclusive, to help older people to stay healthy and active and to encourage their contribution to the community. Councils need to accept responsibility for investing in opportunities and services for older people; to see them as full citizens and as a resource for society, rather than as dependent on it.

10. Because many people see the elderly as dependent and frail, rather than as citizens with a contribution to make, the response of public services is often limited. Services for older people have been focused predominantly on a narrow range of intensive services that support the most vulnerable in times of crisis. Older people are seen as NHS and social care "problems"; any one time, only about 15% of older people are in immediate touch with care services; meanwhile the majority receive little attention.

11. This study argues that we need a fundamental shift in the way we think about older people, from dependency and deficit towards independence and well-being. When they are asked, older people are clear about what independence means for them and what factors help them to maintain it. Older people value having choice and control over how they live their lives.

What seems to be the matter: Communication between hospitals and patients [published 1993]

12. Individual patients have different needs, preferences and expectations in relation to clinical information. Nevertheless, when they are asked about their experience in hospital, the theme that recurs most frequently is their desire for more information about clinical matters. Here are examples of what patients told our researchers:

Benign Prostatic Hyperplasia:

"They never told me it was my prostrate. I think they expected me to know"

"Perhaps it (cancer) should be talked about a little more to put your mind at rest"

"He didn't tell me much more about the operation, only that I needed it"

"They don't discuss much with patients. I would have preferred that they had explained more."

Breast Cancer

"I didn't even know if it was malignant . . . Perhaps they leave it to your imagination"

"I don't think you get enough counselling . . . it seems like they all want to avoid the subject"

"They just told me I was going to have a mastectomy. No choice, no explanation"

"I was told 'it's best to have it all off' but I still don't know why"

"I felt that if I hadn't asked [about radiotherapy treatment], I wouldn't have been told half the things."

Rheumatoid Arthritis

"Why is it that no-one wants to discuss it. . .?"

"They just say 'keep moving, it will stop one day'. . . . They could tell you there's not much they can do—be straight with us"

"It wouldn't hurt to know the side effects of the drugs."

Stroke

"You have to fight to be told what's wrong . . ."

"[I] would like to have known about my condition, treatment and the future. . ."

"I would have like to have discussed aftercare"

"If I'd been given some information when I had the first attack and . . . told . . . what was really wrong, it would have stopped me from getting worse."[78]

[78] *Source:* Patient interviews by the College of Health on behalf of the Audit Commission.

Social Care

13. The social care sector is operating within a context of rising demand and increasing expectations.

All Our Lives: Social Care in England 2002/2003 [published March 2004]

14. The report provides a commentary on the performance of social care services in England in 2002–03. It was produced jointly by the Social Services Inspectorate (SSI), the National Care Standards Commission (NCSC) and the SSI/Audit Commission Joint Reviews team. It combines evidence from these three sources, including early findings from NCSC's inspections of care homes as well as conclusions about the performance of council services in 2002/3. These extracts from the report show how the issue of choice occurs repeatedly throughout social care:

> *Choice, flexibility and respect are the qualities that many adults said they were looking for in social care services. [page 11];*
>
> *Continuing closures of care homes are creating a shortage of places in some regions, reducing the choices available [page 23] . . . Home closures have also disproportionately affected people with dementia. This means that in some parts of the country there is a serious lack of choice. [page 27];*
>
> *Without good planning, care is likely to be inconsistent and uncoordinated and personal choices and requirements will be overlooked. [page 29];*
>
> *Continuing to increase the range of choices available to older people, and helping them to exercise those choices, especially by offering more older people direct payments and ensuring that they are better informed about their rights and entitlements and about the services available. [page 29];*
>
> *Four principles underpin the government white paper Valuing People [published in 2001]; these are—rights, independence, choice and inclusion;*
>
> *Some good progress has been made in offering people with learning disabilities a wider choice of accommodation options;*
>
> *More people are taking up the option of using direct payments—cash payments that promote independence by enabling people to make their own decisions about purchasing care services and so gaining greater choice and control over their lives;*
>
> *Direct payments have transformed my life—now I know and can trust my carers—I have chosen them myself—I have confidence in the support available—I am a different person;*
>
> *Enabling people to have greater choice and control over their lives and to live the way they choose by means of increased access to direct payments, better involvement in care planning, and improvements to the quality of care options. [page 41].*

Services for Disabled Children [published September 2003]

15. Over 240 disabled children and their families told us what matters to them, described their experiences of public services, and shared their ideas for service improvement. We took these views back to services.

16. We found: a lottery of provision, dependent on where people live, and how hard they pushed for the services they need; too little being provided, too late, with long waits for information, equipment and treatment; a maze of services, that frustrates and confuses families; and pockets of good and innovative practice, and service champions. For example:

> *In many cases families faced the choice of using a service where their child felt out of place because of their age, or not having a service at all;*
>
> *Many families felt frustrated that, for much of the time, the help that they needed was not given at the time they needed it, nor was it the kind of help they needed. They described problems with services in relation to meeting individual needs; being consulted on preferences; and cultural awareness;*
>
> *"What do they think? That I don't have a view, that my views don't count, that I don't know or care about my daughter, or that what they do has no impact on anyone else, including the children they're teaching? Do you see how little sense it makes not to involve me as a partner in Amy's care?"*
>
> *While parents might be consulted, disabled children and young people themselves might not be. They recognised that this could cause problems. One housing representative said:*
>
> *"Users need greater awareness of what's on offer so that they can identify their choices."*

Older People—Independence and Well-being [published February 2004]

17. We live in an ageing society. In the UK, the 2001 census has shown that, for the first time, there are more people aged 60 and over than children under 16. We prepared this report in collaboration with Better Government for Older People. This report summarises a series of five reports that explore the nature of change required from public services in relation to the independence and wellbeing of older people. It covers both the majority who have no need of care services (but who have a wide range of other concerns), and the minority of frail older people who may need support and care.

18. The reports in this series are:

18.1 Older people: a changing approach;

18.2 Older people: building a strategic approach;

18.3 Supporting frail older people;

18.4 Assistive Technology;

18.5 Support for carers of older people.

19. The most important messages about choice from these studies are:

> *Older people have strong and consistent views on what helps them to stay independent. At the heart of older people's sense of independence and well-being lies their capacity to make choices and to exercise control over how they live their lives;*
>
> *The expectations of older people are changing, as the young adults of the 1960s move towards retirement. They have very different attitudes towards independence, care and participation, and different expectations of public services from today's older people, who grew up with a vision of a "cradle to grave" welfare state The next generation will be more confident in demanding greater choice and control over the way that services are delivered;*
>
> *. . . the choices more and more older people are making and the lives they are choosing to live, challenge fundamental preconceptions about how government and society at large, views them. Yet whilst older people are changing, the public services they are offered remain rooted in the old paternalistic welfare culture . . .;*

20. If older people are to exercise choice about where to live, they need a range of housing options from which to choose, as well as advice on what is likely to be most appropriate for them. Local planning and housing strategies must allow for a range of flexible options, including support to allow older people to remain in their own homes, as well as sufficient supported housing, including extra care sheltered housing that meets older peoples' priorities in terms of space, design and location.

Take Your Choice: A Commissioning Framework for Community Care [published December 1997]

21. Since the implementation of the community care reforms, social services departments have taken on increasing responsibilities for commissioning community care. Commissioning is the process of specifying, securing and monitoring services to meet individuals' needs both in the short and long term. This practical handbook covers the purchasing process as well as a strategic approach to shaping the market for care to meet future needs. Our handbook helps departments to develop their approach to commissioning, by setting out a framework which they can use to look at their arrangements.

> *"Users and carers should be at the heart of the commissioning process . . . the centre must help users to make informed choices, enable them to complain and get action when things go wrong, and take on board their views in commissioning services for the future.". . .*

22. The necessity of involving and consulting users runs throughout the framework. Section 2 of the manual is entitled "Making commissioning user-led". It emphasises the importance of helping users influence and control their care, for example—by supporting user choice:

22.1 Providing the information users need on services;

22.2 Promoting choice of provider through administrative arrangements; and

22.3 Promoting choice of provider through contract arrangements.

> *The ability of users and carers to make an informed choice over what, where and by whom, care is to be provided is of huge importance . . . For most older people this is likely to be a choice about where they will spend the rest of their lives . . . Authorities should seek:*
>
> *To help users make an informed choice;*
>
> *To ensure artificial barriers to choice are not established by contracting arrangements; and*
>
> *To help ensure choice is offered, by recording and monitoring the choices offered and made.*

23. The handbook contains many examples of good practice.

HOUSING

Promoting Positive Practice [published March 2003]

24. This part of the Audit Commission's Housing Review promotes some of the positive practice found during inspections from 1 July 2001 to 30 June 2002. We found these examples involving choice:

24.1 Ealing Council's choice-based lettings pilots for sheltered housing and on one estate appeared to have achieved service improvements and efficiencies.

24.2 Westminster City Council had also pursued a number of initiatives to increase the options for re-housing, including a choice-based lettings pilot led by Camden, the appointment of a dedicated choice and mobility officer, and participation in the LAWN (London Alliance West, North) project. These initiatives produced flexibility and choice, and better use of stock. In the pilot choice-based lettings scheme, more local applicants had been able to access housing in their preferred areas.

24.3 The "Choices Steering Group" of tenants, officers and councillors in Gloucester City Council used theatre (through a play performed by tenants and officers) to explain the various options for the future of its homes. Meetings of the Steering Group were video-recorded so that other people could watch the debate unfold.

Memorandum by the National Audit Office (CVP 12)

1. Choice is a keystone of the current phase of public service reform. Enhancing public service users' choice is being championed not just as a beneficial end in itself but as a means of helping to make public services more responsive, drive improvements, stimulate innovation and give more voice to the user.

2. The Select Committee on Public Administration has launched an enquiry into choice and voice in public services and wishes to explore the relationship between enhancement of choice and equity, the availability of resources and capacity to offer choice and the appropriateness of offering choice in different services and circumstances. This memorandum is intended to form part of the background evidence for the Committee's enquiry.

3. The National Audit Office has a remit to support beneficial change in the delivery of public services and to report to Parliament. By examining four key choices in public services with reference to users in Birmingham, this memorandum intends to highlight some of the key practical issues the implementation of enhanced choice raises and provide pointers to matters the Committee may wish to pursue further.

4. Most citizens will face one or more of these four choices at one time in their lives while many people will do so several times. They are:

— choice of secondary school;

— choice of General Practitioner;

— choice of hospital for elective surgery; and

— choice of social housing accommodation.

5. The memorandum is set out as follows:

Part 2 examines the reality of choice—the existing extent of choice and the initiatives to enhance it;

Part 3 examines the relationship between choice and information; and

Part 4 examines users' perceptions of the value and implications of choice.

6. This memorandum focuses on one key form of choice—that of the individual user. Annex A tabulates the wider application of the concept of choice to public sector provision.

1. Introduction

"Choice acknowledges that consumers of public services should increasingly be given the kind of options that they take for granted in other walks of life". Office of Public Services Reform[79]

7. The memorandum is based on evidence received from officials at the Department of Health, Department for Education and Skills and the Office of the Deputy Prime Minister as well as regional and area authorities and local service deliverers. We examined published Departmental research and evaluations on choice based issues. We also commissioned the MORI social research institute to carry out a small scale quantitative and qualitative survey of users' views of choice in the Birmingham area.

8. Annex B summarises relevant findings and recommendations of recent National Audit Office reports that have examined choice and equity issues.

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[79] Reforming our public services: Principles into Practice, Office of Public Services Reform, March 2002.

9. A number of themes emerge as a result of National Audit Office work:

Enhancing choice does not of itself lead to greater equity or inequity. Choice appetite is not uniform and not everyone is equally equipped to make a choice or to make their choice heard. All users need to be helped and supported appropriately in articulating their preferences and needs. Choice based service delivery initiatives can help to improve equity if they lead to better identification, support and provision for disadvantaged groups.

Individual choices may conflict with the choices available to others. Because not all choices can be met within existing capacity, administrative systems for allocating services need to be simple, equitable and transparent so that users understand and have confidence in them.

Users require relevant information in appropriate forms to enable them to make informed choices. There is still a considerable way to go in many areas of public provision to ensure users have sufficient relevant information to inform their choices. Users want independent information they can trust.

Enhancing choice requires flexible systems for allocating funds. Responsiveness will be essential to enable timely allocation of resources to the services people choose over others.

Capacity is a key limiting factor in enhancing choice but this does not prevent public service providers from identifying innovative methods of offering choice within existing capacity constraints. The pilot schemes offering choice of elective surgery between different hospitals are designed in part to use local surplus capacity to reduce waiting times. Choice based letting schemes allow more choice of accommodation to tenants within existing social housing stock constraints.

Evaluating the costs and benefits of enhancing choice is complex but vital. The cost of initial investment and capacity building may be relatively high with expected benefits qualitative, longer-term and more difficult to measure. Nevertheless evaluation is vital to ensure lessons are learnt and spread.

10. This part of our memorandum considers the current reality of choice in four key public services and provides a summary of the initiatives being undertaken to enhance choice.

Choice of secondary school[80]

11. Between the 1960s and the 1980s, educational policy assumed that the vast majority of children would attend their local mixed-sex comprehensive. However in many areas a significant minority of parents would choose to send their children to voluntary-aided or voluntary-controlled (usually faith schools) or to single-sex state schools.

12. Since the 1980s policy has been to encourage diversity and introduce incentives to help drive up educational standards. The Education Reform Act 1988 allowed some schools more independence to manage their budgets and determine their own policies on teaching. The Education Act 1993 allowed schools to specialise in certain subjects and choose pupils with aptitudes in those subjects. The Learning and Skills Act 2000 provided for the establishment of City Academies—a new type of publicly funded secondary school for urban areas. In 2003 the Department for Education and Skills set out its aim to encourage diversity further through a range of measures including the planned granting of specialist status to some 2,000 schools by 2006[81].

13. Under the School Standards and Framework Act 1998 parents have the right to express a preference about the school to which they send their children. Admissions authorities (the local education authority for community and voluntary controlled schools and the governing body for voluntary aided and foundation schools) have a duty to comply with that preference except in a specified range of circumstances. In the case of secondary schools, compliance with parental preference does not apply if it would prejudice efficiency or not be compatible with the selection arrangements of a school that selects by high ability. Local Education Authorities have the task of resolving the tension between managing the provision of, and access to, secondary school places effectively and efficiently whilst also fulfilling their legal obligation of meeting parental preference wherever possible.

14. The Schools Admissions Code of Practice[82] requires admission arrangements to be clear, objective and to give every child a fair chance of a satisfactory school place. Admission authorities are responsible for setting their own admissions arrangements in all areas and decide their own priorities for allocating places if the school is oversubscribed. Commonly used criteria include sibling link to pupil at the school, catchment area, feeder schools and distance from the school. Designated faith schools can give priority on the basis of faith. Designated grammar schools can give priority on the basis of academic ability.

[80] This section draws on the results of an evaluation undertaken by the Social Survey Division of the Office for National Statistics for the Department for Education and Skills—"Parents' Experiences of the Process of Choosing a Secondary School", 2001.

[81] "A New Specialist System: Transforming Secondary Education", Department for Education and Skills, 2003.

[82] School Admissions Code of Practice, Department for Education and Skills, 2003.

2. The Reality of Choice

"Far too often the choices reality proposes are such as to take away one's taste for choosing". Jean Rostand.

15. Parents living in more densely populated areas will have a greater number of schools within reasonable travelling distance to choose from. Most Local Education Authorities invite parents to express a preference for more than one school. Some including Birmingham allow parents to rank their preferences. Birmingham has a wide range of choice of different types of secondary school, most of which are easily accessible with good transport links. A significant number of these are grammar schools and others which have some form of selection. Grammar school applications are oversubscribed many times and parents put these schools high up their lists of preference. Parents of children who are unsuccessful in selection tests still have later community school preferences considered equally against those of other parents who may have put community schools as a higher preference. Parents therefore may not necessarily be dissatisfied if they fail to obtain the school they identified as their first preference on the local education authority application form.

16. At present parents in many areas may apply to more than one admission authority, for example to more than one local education authority, or to their own local education authority and to a school that is its own admission authority (such as foundation or voluntary aided schools). Parents may therefore receive more than one offer of a school place for their child. From 2005 parents will complete the common application form of the local education authority in which they live and use the form to apply to any maintained schools they wish their child to go to regardless of where they are situated. The local education authority will act as a clearing house and notify the admission authorities of the schools that the parent has applied for. The admission authority will notify the local education authority about whether the parent can be offered a place. Where a parent can be offered more than one place, the local education authority will apply criteria to decide which place is offered, usually the one the parent ranks highest.

17. A Departmental evaluation of parents' experience of the process of choosing a secondary school concluded that the fact that parents may be able to choose from a wide number of schools is not necessarily something that works in parents' interests[83]. Few parents may be committed to an abstract concept of "choice". It is more likely that they want choice when the alternative would be to have something imposed on them that they do not want. The wider the choice the greater the uncertainty for at least some parents. Parents are more concerned about whether the overall outcome of the admission process can be predicted/manipulated than the overall extent of choice of school.

18. Departmental research suggests that nationally about 85% of parents are offered a place in their favourite school (defined as the state school they most wanted their child to attend)[84] (Figure 1). 96% of parents received an offer of a place in a school for which they had expressed at least some preference. Some 4% of parents were offered a place in a school for which no preference had been stated. Some parents do not apply to popular schools because they are over-subscribed. Eight per cent of parents reported that there were other state schools they would have preferred for their children over the ones for which they applied.

19. In London the proportion of parents receiving a place in their favourite school was considerably smaller—68%. Nationally the impact of a mother being from the black or other minority ethnic communities was to decrease the likelihood of being offered a favourite school by half. Non-employed lone parents were twice as likely to express dissatisfaction with the outcome of the school application process as dual employed couples.

Proportion of parents offered places in preferred schools and schools for which no preference was stated

Source: Parents' Experience of Choosing a Secondary School DFES 2001

Offered a place (%)

In a preferred school

Favourite school 85

Any school for which preference expressed 96

In a school for which no preference stated 4

Parent satisfied with outcome 2.1

Parent dissatisfied with outcome 1.4

No view 0.3

Weighted base 2170

[83] Parents Experience of Choosing a Secondary School. Department for Education & Skills, 2001.

[84] Parents Experience of Choosing a Secondary School. Department for Education & Skills, 2001.

20. The key limiting factor in meeting parental preferences is that popular schools do not have the capacity to accept all pupils put forward for admission. Most Birmingham schools are oversubscribed and there is competition for places. Wherever possible the local education authority responds to parental choice by expanding popular schools. However schools are not always willing or able to expand and some parental desires (for example for more single sex education) do not fit in with local policy or the practicalities of running an area-wide education service. Birmingham Local Education Authority told us that the key factor was to provide a balance between an acceptable level of choice and an unacceptable level of surplus capacity.

Choice of General Practitioner (GP)

21. A key determinant of the extent of choice of GP is the local availability of primary medical service providers. On average there are 53.2 GPs per 100,000 patients in England[85]. But there are marked inequalities in distribution. In 2000 there were 50% more GPs in Kingston and Richmond or Oxfordshire than there were in Barnsley or Sunderland after adjusting for the age and needs of their respective populations[86]. In some areas there is difficulty in getting onto practice lists. Some estimates suggest that close to 15% of the population live in areas where practice lists are closed to new patients[87].

22. In April 2002 local Primary Care Trusts assumed the responsibility for planning the primary care workforce and overseeing the geographical distribution of GPs. New funding arrangements introduced at the same time, take account of the extent to which areas are under or over their fair share of general medical services expenditure. In West Midlands Central Strategic Health Authority which covers the Birmingham area there were some 1,315 GPs in post in 2001. By the end of 2005 it is planned for this number to rise to 1,443.[88]

23. Where patients are experiencing difficulty in registering with a practice themselves they can seek help from their local Primary Care Trust, who can if need be assign the patient to a practice list. In doing so the Primary Care Trust has to take into account a number of considerations such as the needs of the patients and the distance between the practice premises and the patient's home. In very limited circumstances the Primary Care Trust can place an individual with a practice even where the practices' list is formally closed.

24. New formal procedures for closing lists and for assigning patients to practices with closed lists came into effect in April 2004. These are intended to help patients know the practices where they can register. A practice whose list is open can refuse to accept a new patient onto its list of NHS patients but the practice must give reasons for the refusal in writing. The practice must also maintain a record of refusals so this can be monitored by the Primary Care Trust. An increasing proportion of funding under new General Medical Service Contracts is capitation-based so operating a closed list will have a greater adverse effect on a practice's income.

25. Primary Care Trusts contract for delivery of primary medical services with a range of alternative providers: commercial providers, not-for-profit organisations, the voluntary sector, or with other Primary Care Trusts. By establishing a means of providing primary medical services other than with independent GP contractors, the Primary Care Trust can offer patients an alternative to being assigned to a practice. However this may not be possible where there continues to be insufficient supply of local GPs, or in large rural areas where alternative providers may be too far from a patient's home. Once a practice has undergone formal closed list procedures, Primary Care Trusts may only assign a patient to that practice with the approval of an assessment panel or the Strategic Health Authority on appeal.

26. In Birmingham additional expenditure of £6.5 million in 2004–05 and £12.8 million in 2005–06 is planned to improve primary care services. National spending on primary care services is planned to rise by a third to £8 billion by 2008. Additional funding will be directed in two key ways: to provide additional GPs and encourage doctors who have recently completed GP training to take up substantive GP posts, encouraging doctors to return to a career as a GP especially through improving the possibility of part-time work, and international recruitment from other EU countries. There will also be an increase in alternatives to treatment by a GP, including:

- E-service options such as NHS Direct, NHS Direct Online, and NHS Direct Digital TV as sources of advice and information;
- access to practices through e-mail and telephone consultations;
- walk-in centres offering immediate help for acute problems without an appointment such as that planned for South Birmingham; and
- devolution of some services previously only offered by GPs or hospitals to other NHS staff including nurses and pharmacies[89].

[85] "Shifting the Balance of Power: New Arrangements for Managing General Medical Practitioner Appointments" Department of Health letter to Chief Executives of Primary Care Trusts, March 2002.

[86] "The National Health Service Plan: A Plan for Investment, a Plan for Reform", Department of Health, July 2000.

[87] "Building on the Best: Choice, Responsiveness and Equity in the NHS" Department of Health,December 2003.

[88] "Shifting the Balance of Power: New Arrangements for Managing General Medical Practitioner Appointments" Department of Health letter to Chief Executives of Primary Care Trusts, March 2002.

[89] "Building on the Best: Choice, Responsiveness and Equity in the NHS" Department of Health, December 2003.

27. Under the New General Medical service Contract patients now register with a practice or other primary medical service provider, rather than an individual GP. Patients will still continue to be able to ask to be seen or treated by a particular practitioner working for the contracted service provider. This could for example be the same GP for a continuing case, or for a particular condition, or another GP who specialises in that area. When a patient registers with the practice they are advised to ask patients if they want to name a preferred practitioner; for example, some women prefer to see a female GP. The general assumption is that the GP with whom patients are currently registered will continue to be the preferred GP. When patients next attend their practice they will be asked to record an alternative preference which should then be recorded on their medical record.

28. Choice of practitioner is not absolute. It depends on the availability of the preferred practitioner as well as appropriateness. When a patient asks to see a particular practitioner, the practice will be required to endeavour to meet these wishes and take into account the following:

— the availability of the health professional—the patient may have to wait longer to see their preferred practitioner;

— patients should bear in mind their general obligation not to unfairly discriminate for example by refusing to see a doctor of a particular ethnic minority;

— the practitioner will still be allowed the right of reasonable refusal such as in relation to violent patients or the safety of practice staff;

— the patient may be asked to accept an alternative if, for example, the service required is nurse-led or therapist-led rather than doctor-led.

Choice of Hospital for Elective Surgery

29. Most choices over provision of secondary care healthcare are currently exercised by a GP on behalf of the patient. Patients cannot approach the specialist of their choice without a referral, except in emergency situations.

30. Prior to 1991 GPs could refer patients to the specialist of their choice and patients could request a referral to any consultant who would take them, with movement of patients across authority boundaries being monitored and funding allocated accordingly. In 1991 a series of NHS reforms were implemented including the development of an internal market which effectively limited the extent of cross boundary movement and halted the previous pattern of referrals. Non-fundholding GPs in particular became limited in the choice of specialist they could easily refer their patients to although the Patients Charter[90] did provide for the right to be referred "to a consultant acceptable [to you]".

31. In 1997[91] the Labour government announced they would be abolishing the internal market and by 1999[92] this had resulted in the creation of Primary Care Groups across the county which subsequently evolved into Primary Care Trusts. This reform placed GPs and Primary Care Trusts at the forefront of commissioning services for patients in their locality. However GPs still need to clear "out of area referrals" with the Primary Care Trust.

32. The NHS commitment to introducing further choice in healthcare was built into policy from 2000 when the NHS Plan emphasised the need for greater information provision and by giving a commitment that patients requiring elective treatments would be given a choice about when and where they were treated. The Department of Health considers that the benefits for patients of giving greater choice of provider for elective treatments will be:

— greater involvement and control over their treatment, so that choices reflect the patients' priorities;

— faster treatment;

— greater certainty over the time they will be treated;

— reduced variation in standards of care, as more standardised care pathways are introduced and patients apply pressure for higher standards; and

— greater equality of choice for all patients[93].

33. In July 2002 the NHS introduced a series of pilot schemes trialling patient choice of treatment at alternative hospitals for patients waiting over six months for elective treatment. While the introduction of the pilots was intended to be a step toward the NHS aim of greater involvement and control for patients in their own care, it was also expected to substantially reduce waiting times in the areas where it was introduced.

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90 The Patients Charter 1991 Department of Health.

91 The New NHS: Modern, Dependable.

92 The Health Act:1999.

93 "Choice of hospitals: guidance for PCTs, NHS Trusts and SHAs on offering patients choice of where they are treated", Department of Health, July 2003.

34. This initiative initially included a national coronary heart disease pilot for heart surgery and eight regional pilots across specialities with the highest waiting lists, typically ophthalmology, orthopaedics or general surgery (Figure 2). By the end of 2003 these pilots had broadened the range of specialties in which they offered choice, while several Strategic Health Authorities had developed their own pilots.

35. By August 2004 the Department of Health intends that all patients who have been waiting six months or more for elective surgery will be able to choose the location and, by using patient pre-booking systems, the timing of their treatments[94]. This will be the case for most specialisms but there may be a few services where a national shortage of appropriately qualified surgeons means this is not possible.

36. These initiatives have been accompanied by a change in the way funds are allocated within the NHS. In April 2003, the "payments by results" initiative began its phased implementation and NHS trusts now receive part of their income on the basis of a fixed cost per case for specific treatments. The range of procedures covered by "payments by results" will increase considerably in 2004–05 and 2005–06. It is intended that the combination of patient choice with the movement of funds will put pressure on high-cost providers to improve their productivity.

37. By 2005 the Department of Health plans that patients requiring elective surgery will be offered a choice of four to five hospitals or other appropriate providers once the GP has decided that a referral is required. This is expected to benefit over nine million patients each year. Providers could include NHS Trusts, Foundation Trusts, Diagnostic and Treatment Centres, private hospitals and practitioners with a special interest operating within primary care. The menu of choices from which the patient will be able to choose will be decided by the Primary Care Trust. Having chosen their provider, it is planned that patients will be able to book their appointment (in many cases electronically) for a time and date that suits them.

38. Research commissioned by the Department of Health based on pilot areas where patients had been offered a choice of hospital at the point of GP referral found that patients valued the offer of a choice but that most patients opted to go locally. The research suggests that relatively few patients would currently make use of choice at the point of referral to seek out better or faster treatment even though most welcomed the opportunity to be able to do this[95].

Choice of Social Housing Accommodation

39. Local authorities have a statutory responsibility[96] to ensure that advice and information is available free of charge to persons in their district about the right to apply for an allocation of housing accommodation. Allocation schemes must include a statement of the authority's policy in offering people:

- a choice of housing accommodation; or
- the oportunity to express a preference about housing accommodation.

Details of NHS pilot schemes offering choice of secondary care for elective surgery

National Coronary Heart Disease Cardiac July 2002 2,549 (as of May 2003)

London Patient Choice 12 including Cataract and most elective care July 2002 9,500 (2002–03) 22,550 (2003–04)

Greater Manchester General Surgery, Orthopaedics, Ear Nose and July 2002 6,425 FFCEs

Throat, Ophthalmology

Berkshire Plastic Surgery, General Surgery, Ear Nose and July 2003 Less than 1,000 Throat, Dermatology Surgery and MRI scans

Cataract Choice South Cataract July 2003 22,000

Dorset and Somerset No specialties excluded September 2002 600 (2002–03)
N/A (2003–04)

Trent All particularly Ophthalmology and Orthopaedics July 2003 N/A

West Yorkshire Ophthalmology April 2003 1,414 (2003–04) 2015 (2005–06)

Surrey and Sussex General Surgery July 2003 N/A

Urology Surgery

Source: Department of Health.

[94] "Choice of hospitals: guidance for PCTs, NHS Trusts and SHAs on offering patients choice of where they are treated", Department of Health, July 2003.

[95] Implications of offering "Patient Choice" for routine adult surgical referrals, Project Final Report, dr foster, March 2004.

[96] Section 15 of the Homelessness Act 2002.

40. Many local councils including Birmingham currently operate a points based assessment of need in order to allocate available accommodation. Each application is given a certain number of points based on factors such as: medical condition, homelessness, overcrowding in current accommodation, and social circumstances. People with the most points will be given the most priority on the list. Sometimes points are also awarded for the length of time applicants have been on the waiting list. Priority standing entitles applicants to one offer of accommodation that the council considers is suitable to meet the applicants needs. Applicants who reject this offer are placed on the council waiting list. An applicant who refuses three offers loses their place at the top of the list and may have to wait a considerable time before being offered a place again.

41. In traditional allocation methods involving points-based systems and housing registers, need is defined by housing professionals and local authority policies and practices. The relative number of points given for a particular factor can vary considerably between adjoining authorities even though they may cover the same local housing market. "Need" is often defined relative to the nature of the local housing market and the demand for social housing. In London, for instance, there has been a growing recognition that key workers, such as nurses and teachers, are unable to afford owner-occupied property, but they are often ineligible to apply for social housing. In other areas of the country, such groups have been identified as part of new niche markets for social housing and definitions of "need" have been altered allowing such groups to exercise more choice about their housing circumstances.[97]

42. District-wide quantitative oversupply of social housing stock can mask more specific qualitative issues in an area such as the oversupply of some types of property like sheltered housing or one bedroom flats and undersupply of others such as large family accommodation. There may well be relatively high and low demand areas within a single district. In local areas where there is a surplus of social housing, allocation systems based on rationing a scarce resource become less appropriate. This has encouraged local authorities and social landlords to rethink aspects of their lettings policies including advertising and marketing low demand estates. Even in parts of the country where there is a more consistent pattern of severe shortages of housing (for example, in London, and the South East) some social landlords have introduced or are considering introducing an element of choice into their allocation systems.

43. The April 2000 Green Paper, "Quality and choice: a decent home for all"[98] encouraged local authorities to develop new approaches to allocation systems with the aim of encouraging a greater degree of choice. This was given a statutory basis in the Homelessness Act 2002. The Office of the Deputy Prime Minister has sponsored 27 pilot schemes which introduce an element of choice for the prospective tenant.[99] These are based in part upon successful systems operating in Europe. Sandwell was one of the areas piloting choice-based letting and Birmingham intends to move to operating such a scheme by 2005.

44. Although choice based letting schemes differ in the detail of their operation,they all involve the general principle of allowing the prospective tenant, rather than the housing officer, to make the decision as to whether to apply for a property. All schemes involve some element of advertising vacant homes. In Sandwell available properties are advertised through the press and direct mail, the internet and public display. Adverts for the property are advertised with "household type" most suitable for that property (eg minimum of two persons for a two bed house). The applicant expressing an interest who most closely matches the advertised "household type" will be offered the property. In the event of two expressions of interest being equal, the applicant who has been registered the longest will be successful. Those who are assessed as priority need still get priority but this is done through a banding scheme rather than the points system, and these tenants can still exercise choice rather than having to take the first place available and lose their priority status.

45. The early findings of Departmental evaluations indicate strong support for choice based letting systems, with some 80% of tenants in one area surveyed preferring this model to the traditional system it replaced. Most tenants agreed that the new systems gave more choice and control to applicants.[100]

46. Early indications in Sandwell are that the choice based letting scheme will bring additional operational and community benefits. The ratio of let to unlet properties has improved as previously unpopular properties have been better marketed. Although initial investment was required to introduce a choice based system, savings are expected to accrue from less staff time spent in contacting prospective tenants. It is hoped that tenants who have exercised greater choice in their accommodation will have greater commitment to their property and community.

47. The Office of the Deputy Prime Minister aims to have 25% of local authorities adopt some form of choice based letting scheme by 2005 and expects that all authorities will offer some form of choice to applicants by 2010.[101]

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[97] "Needs Versus Choice in Social Housing Allocation Systems", Tim Brown, Centre for Comparative Housing Research, Paper presented at the ENHR 2000 Conference in Gavle, 26–30 June 2000.

[98] "Quality and Choice: a decent home for all", Office of the Deputy Prime Minister, April 2000.

[99] Pilot Scheme to Test Choice-based Housing Lettings Approaches—Office of the Deputy Prime Minister, March 2001.

[100] Applicants' Perspectives on choice based Lettings—Second Draft Report, Office of the Deputy Prime Minister, December 2003.

[101] "How to choose choice: Lessons from the first year of the ODPM's pilot schemes", Office of the Deputy Prime Minister, October 2002.

48. In order for people to make informed choices they must know that a choice is available and they need sufficient relevant information and appropriate support to guide them in making their choice. This part of the memorandum considers the relationship between information and choice in the services examined.[102]

49. Of the four services, users in Birmingham were most satisfied with the amount of information available to choose a secondary school (Figure 3). Some 96% considered there was a "fair amount" or a "great deal" of information available. But less than a third of users believed there was a similar level of information available to inform their choice of GP or social housing accommodation.

Choice of Secondary School

50. A variety of sources of formal information are available to inform parents' choice of secondary school. All admissions authorities are required to publish details of their own admissions arrangements. The School Admissions Code of Practice states that parents are likely to find it helpful to have in one booklet the information for all schools to which they are likely to apply and that parents ought to be provided with relevant information in plain English and other commonly used community languages. Local Education Authorities do this by publishing composite prospectuses containing details of all local schools.

> *"It's no good having choice unless we all have all the information we need to make the choice and information we can trust"*
>
> Birmingham user of public services

51. Other formal literature is also available to parents and includes school prospectuses, OFSTED reports and performance tables compiled by the Department for Education and Skills and which are published in newspapers and available on the Internet.

52. A national study of parents' experience of the process of choosing a secondary school found that the provision of information by admissions authorities was variable.[103] A particular weakness in many composite prospectuses was a failure to contextualise information. It is a statutory requirement to publish the over and under-subscription figures for schools but by themselves the numbers may not mean very much. In many local education authorities little guidance is provided to help parents to predict the likely outcome of expressing particular preferences. Some local education authorities published more useful information such as the furthest a parent could live from a school and still gain a place. However the validity of such information can change from year to year making it difficult to use prior year information as strict criteria for following year admission.

53. The study found that over-subscription criteria for popular schools were often expressed ambiguously. For example, in one local education authority, priority was stated as being given to ". . . pupils living nearest a school defined 'as the crow flies' . . . with account being taken of physical barriers or issues of safety of movement by pupils".

54. In 2001, around eight out of 10 parents used one of the formal sources of information available to them to help inform their choice. School prospectuses were used by 69% of parents but other official literature was used by less than half. The likelihood of using one or more formal sources of information was five times greater for parents if the mother had qualifications at degree level or above than if the mother had no qualifications.

55. Nearly 40% of parents used performance tables to find out about schools. Of these parents, almost one third found them "most useful" whilst 14% found them "of little or no use". Parents in London were twice as likely to consult performance tables as parents in rural areas. Parents among whom the mother had educational qualifications at degree level or above were nearly twice as likely to consult performance tables as those among whom the mother had no educational qualifications.

56. Despite these formal sources of information, the most common sources of information used by parents are informal. The two most frequently cited sources of information used by parents surveyed were visits to schools and talking to other parents. These two most commonly used sources were also rated the two most useful.

Choice of General Practitioner

57. Information about registering with a GP is available from local Primary Care Trusts. Prior to 1 April 2004, each Primary Care Trust was required to maintain a Directory of Family Doctors. This Directory will be replaced later this year, subject to legislation, with a new Primary Care Trust Guide to Primary Care Services. The amount of information currently made available by each Trust covering the process of being registered, assigned or transferred and the surgery hours and other facilities at individual practices varies.

[102] It draws on the survey of service users carried out by MORI on the National Audit Office's behalf in Birmingham as well as evaluations carried out by the Department for Education and Skills, the Department of Health and the Office of the Deputy Prime Minister.

[103] "Parents' Experiences of the Process of Choosing a Secondary School", Department of Education and Skills Report 2001.

Information on how or where to register can also be obtained from Primary Care Trusts, the Primary Care Trusts's "your Guide to Local Health Services", practice leaflets, NHSDirect, the NHS UK website, Patient Forums, libraries, Citizens Advice Bureaux, and post offices.

58. From April 2004, new contract regulations set out the information that practice leaflets must contain. The practice leaflet must be reviewed annually and amendments made to maintain its accuracy. Key requirements include:

- names of clinical staff and partners;
- details of how to register, ability to specify a preferred practitioner, and a description of the practice area;
- the services available and Primary Care Trust details (to obtain information about additional services that are not provided by the practice);
- the appointment system and normal surgery hours;
- whether the practice premises have suitable access for disabled patients;
- the name and address of the nearest local walk-in centre;
- the method of obtaining repeat prescriptions;
- how to make complaints; and
- the responsibilities of the patient, including keeping appointments and respect for race, gender and disability.

60. The current lack of easily available information available on different GP surgeries was the most common reason cited by Birmingham users for difficulty in choosing a GP (Figure 4). When asked how they actually went about finding a GP, the majority of focus group participants said they were unaware of the formal sources of information available and relied on informal sources such as friends and family before approaching a practice directly.

Choice of Hospital for Elective Surgery

61 Almost 90% of respondents to the Department of Health's recent consultation exercise on choice in the NHS stated that they needed more information in order to make decisions and choices about their treatment or care.[104]

62. As part of the pilot choice schemes for hospital referral the Department of Health has created a new role of "patient care adviser" to provide a contact point throughout the health choice process from the initial offer of choice to aftercare arrangements. Patient care advisers facilitate the patient's decision process by providing them with information and support. The patient care advisers have access to information and advice from experts and are independent of the NHS, being managed by the local patient advice and liaison service.[105] Patient care advisers in the national cardiac project are typically senior nurses with cardiac experience; they liaise with the National Cardiac Co-ordination Unit, and provide the patient with information on where and when treatment is available. The Department of Health intends to ask Primary Care Trusts to develop targeted packages of support for hard to reach individuals to enable them to exercise informed choices in time for the introduction of choice of hospital at referral in 2005.

63. MORI's survey work in Birmingham indicates that professionals within the NHS may have different views from patients about the relative importance of different types of information patients need to make a choice of hospital (Figure 5). Whilst consultants think waiting time will be the key information on which patients will make their decision about whether to transfer to an alternative hospital, patients do not give it the same significance. Patients are more likely to place emphasis on hospital reputation and quality of care.[106]

64. An evaluation of one of the choice of hospital pilot schemes noted that patients wanted information about specific services rather than generalised, comparative data such as that provided by the Department of Health's performance indicators and star ratings. They tended to distrust government information and preferred the presentational style of an independent commercial information provider, because it gave more detailed locally relevant information.[107].

65. Research carried out for the Birmingham and the Black Country Strategic Health Authority concluded that successful implementation of choice of hospital at referral will to a large degree depend on the pro-activeness and awareness of the GP. Although 53% of GPs expressed a preference for patients to come to them for face to face advice for information on hospital referral, about 60% said as at November 2003 they either had little or none of the information they needed to help their patients make informed choices about health care services.[108]

[104] "Building on the Best: Choice, Responsiveness and Equity in the NHS", December 2003, Department of Health.
[105] "Patients right to choose" Primary Care NHS Magazine, July/August 2002.
[106] "Patient Choice in Birmingham, Solihull and the Black Country" November 2003.
[107] "Patients' experiences of Coronary Health Disease Choices". Picker Institute Europe Report for Department of Health.
[108] "Patient Choice in Birmingham, Solihull and the Black Country" November 2003.

66. Research commissioned by the Department of Health based on pilot areas where patients had been offered choice of hospital at the point of referral concluded that patients and GPs wanted much more information to help them form decisions about where they were treated. Lack of information on which GPs felt confident to recommend services to patients or on which patients might select services made it hard for either to come to a firm opinion that travelling to a more distant hospital would provide a better quality of service. Both patients and GPs wanted better information about clinical performance and in particular information that related not to a hospital but to particular departments, consultants or treatments.

Choice of Social Housing Accommodation

67. Information on applying for social housing is available from local authorities, registered social landlords and other housing organisations. In a number of areas there have been initiatives to improve co-ordination between organisations with the aim of developing common housing registers.

68. Some 70% of social tenants in Birmingham surveyed by MORI believed that the information available to them to make a decision about the accommodation they rented was "not very much" or "none" (Figure 4). In traditional point-based systems potential tenants are given very little choice over the accommodation offered to them and very little information is therefore provided about it. In focus groups a key concern of social tenants was the lack of information landlords or allocation authorities had provided about the area in which they had been allocated accommodation including information about local amenities and facilities (particularly for children and young people) as well as levels of crime.

69. Choice based letting schemes differ from traditional allocation systems in the level of information made available about potential properties available to rent. Properties are much more widely advertised and marketed using approaches such as sending letters and leaflets to people on waiting lists, setting up information kiosks in local supermarkets or high streets and advertising though local newspapers, council newsletters and the Internet.

70. The fact that properties are more openly advertised under choice-based letting has the potential to increase the transparency of allocation systems. But this does not do away with the need for potential tenants to understand clearly the way in which bidding systems work. Departmental evaluations of choice based letting schemes found that where a scheme's staff had given a very good service in terms of explaining the system, encouraging tenants to bid and explaining their unsuccessful bids, the new systems were often perceived as fairer and more transparent.

71. We were told that in Sandwell individuals from the black and other minority ethnic communities were consistently less active than individuals from other groups in applying for social housing under the previous "points based scheme" and consistently exhibited less knowledge of the system. After the shift to a choice based letting system, registrations from potential tenants among the black and other minority ethnic communities markedly increased to 39% of all registrations. The choice based letting scheme attributed this to the implementation of non-traditional marketing approaches including the creation of housing office shop-fronts designed to look like estate agents rather than traditional council offices.

72. Another choice based letting scheme in London led by the Borough of Newham also has a very proactive approach to language provision offering information through a number of channels in 11 local community languages. This approach has helped to ensure that the proportion of potential tenants from the black and other minority ethnic communities making bids on properties under the scheme are broadly in line with their representation on the register of housing.[109]

73. This part of the memorandum considers users' views about choice in the services under examination. It is based on a quantitative and qualitative research study undertaken in Birmingham by the MORI Social Research Institute on the National Audit Office's behalf. In the light of the considerable enhancement of choice planned for secondary healthcare, it pays particular attention to issues in this service and draws on work conducted by MORI for the Birmingham and the Black Country Strategic Health Authority.[110] It covers:

(a) The existing quality of services.

(b) The value of choice.

(c) Choice in the NHS.

(d) Users' key concerns.

[109] *Source*: London Borough of Newham, East London Letting Company.

[110] "Patient Choice in Birmingham, Solihull and the Black Country", Birmingham and the Black Country Strategic Health Authority, November 2003. A total of 1,208 members of the public and 200 GPs and consultants were surveyed.

(a) *The existing quality of services*

74. Users' perceptions of the value of enhancing choice in particular services are associated with their level of satisfaction or dissatisfaction with those services. More than half of the users surveyed by MORI in Birmingham were satisfied with all four services examined. But levels of satisfaction varied considerably between the services, as Figure 6 illustrates.

> *"To decide, to be at the level of choice, is to take responsibility for your life and to be in control of your life."*
>
> Abbie M Dale

75. Of the four services examined, net satisfaction with the local GP surgery was highest. Residents aged over 55 were more likely to be satisfied than younger residents, possibly reflecting the fact that older people are heavier users of NHS services and are frequently more positive about public services. Most of the participants had long-established relationships with their local GP, which they felt were very important.

76. Slightly lower proportions of Birmingham residents were satisfied with their local NHS hospital. Focus group participants were fairly negative when talking about the NHS in general, but more positive about their personal experiences with their GPs and local NHS hospitals.

77. Over half of parents were satisfied with their local secondary school, while 12% were dissatisfied. Fathers were more likely to be satisfied than mothers. Those with children already at secondary school tended to be more positive, whereas those who were in the process of selecting their secondary schools were more critical.

78. Net satisfaction was lowest in regard to social housing with a net satisfaction rate of just 10%. Tenants of registered social landlords were more satisfied than those renting from the local authority.[111]

(b) *The value of choice*

79. MORI's survey work in Birmingham suggests that users do not regard choice in itself to be the most important aspect of public service reform. Choice was seen as less important than ensuring that services meet the needs of the public, are of a good standard and that information is available on them locally (Figure 7). In focus groups people expressed support for choice but not at the expense of improved services generally.

80. However, there was recognition and support for choice as a means to an end-improved services. Across all the services explored, most people believed that enhancing choice would improve the service locally as well as for other people across the country (Figure 8).

Proportion of users who think more choice will improve services locally and nationally

Source: MORI: Choice in Public Services: NAO, February 2004.

Improvement in my area 61 69 77 83

Improvement across the country 69 71 75 81

Base: (524) (524) (187) (107)

81. In all the services examined the majority of users wanted more choice. But there were variations between the services in the degree of enhanced choice users wanted (Figure 9). Users thought enhancing choice was more important for those services which they found less satisfactory—their choice of secondary school and social housing accommodation (Figure 10).

(c) *Choice in the NHS*

82. Almost half of the Birmingham public surveyed by MORI believe that they are already given either a great deal or a fair amount of choice by the NHS (Figure 11 overleaf). Those aged between 35 and 54 are the most negative. Thirty three per cent of this age group feel they have some choice compared to 57% of 16–24 year olds and 50% of those aged over 75. The higher socio-economic groups are also less likely to think they have a choice compared with the lower socio-economic groups.

83. MORI undertook a comparison of the net amount of choice people think they actually have and the importance they place on having choice in respect of particular aspects of healthcare service. This suggested that there are only two particular aspects of healthcare where people feel they have a positive net choice—the GP they could register with and the date and time of consultant appointments. All other areas show a negative net choice (Figure 12). When GPs and consultants are asked the same questions they believe there is a greater level of existing choice than the public.

[111] MORI: Choice in Public Services: National Audit Office, February 2004.

84. MORI asked patients and clinicians (both GPs and hospital consultants) for their views about the planned initiative to provide choice of referral to four or five hospitals for treatment from 2005. Some 77% of patients welcomed the prospect of choice, although the great majority expressed the need for help and advice in making the choice (Figure 13). 15% of patients thought they could make the decision themselves. The overall picture was broadly similar for clinicians, although a higher proportion saw the need for the patient to have support.

85. Men were considerably more likely than women not to welcome personal choice at referral and to prefer to leave decisions to their GP (Figure 14). So were patients aged 55 and over. Nearly half of all those aged over 75 would prefer to leave the decision to their GP. Black and asian patients were also more likely to take the view that the professional should make the choice not the patient. This was also true of those in lower socio-economic groups.

(d) *Users' concerns*

86. Concerns raised in focus groups by Birmingham users' of services about the level of existing choice and the plans to enhance it fell within five main themes:

1. *The limits of existing choice*

Most users recognised clearly that choices existed only within the limits of existing capacity and that this constrained the ability of choices to be met. For social renters, there was recognition that choices are limited because of the shortage of social housing stock. In a similar way many parents recognised that the number of places at more popular schools was limited.

2. *Support for local institutions*

Some users expressed concern that enhanced opportunities to use facilities further afield might weaken loyalty to local institutions. This in turn might lead to further decline in standards of service available locally. This was particularly true in regard to secondary schools and hospitals.

3. *Need for transparency*

Many users expressed the view that systems that allowed users to express preferences needed to be more transparent. This was particularly the case in regard to secondary school and social housing allocation. Parents raised the lack of perceived consistency with which distance from school was used by admissions authorities and the lack of predictability of outcome from expressing preferences. Although the points based system was recognised as a mechanism of rationing available social housing accommodation, doubts were raised by tenants over the consistency and fairness of such allocation schemes.

4. *Equity*

Concerns were also raised that choice could lead to less equitable allocations of provision, with those unable or unwilling to access information or to travel further afield less able than others to benefit from choice.

5. *Need for information and advice*

Whilst some participants expressed confidence in their ability to access the information required to inform their choices, others expressed the need for better advice and support from public service professionals. In general participants expressed a preference for face-to-face advice where possible. Choice is a simple concept but with wide-ranging potential application. This annex offers a taxonomy of choice in public service provision. It provides a brief description of the possible forms of choice together with examples.

Annex A

A TAXONOMY OF CHOICE

A Taxonomy of Choice in the Public Services

Who chooses?

Single citizen

Provider/professional

Democratically elected authorities

Democratic collectives

Collectives

Community representatives

A single public sector service provider

A number of outlets within a single public sector service

A range of public sector service providers

A range of public, voluntary or private sector providers

A range of public, voluntary or private sector providers contracted to a public sector body

Choice is exercised by the individual service user

Choice is exercised by the provider or professional on behalf of the user

Choice is exercised on behalf of citizens by democratically elected authorities

Citizens exercise democratic expressions of preference

Groups of users join together to exercise choice collectively

Representatives exercise choice on behalf of communities

Service provision can be obtained by only one public sector provider, but there may be opportunities for enhanced choice by offering options to users

Service provision is by one public sector provider, but the user can choose the service between different outlets

Service provision is from the public sector, but the user can choose a similar service from different public sector providers

Users choose their service from the full range of public, voluntary and private sector providers, paid from public funds

A number of private and voluntary sector providers are contracted to a local authority to offer distinct forms of a service and/or to allow users to choose between different providers

Patients choose a GP

GPs choose appropriate hospital or consultant on behalf of patients

Local authorities influence priorities and quality of services provided

Choice over whether council-run stock should be transferred to registered social landlord resides with tenants in a ballot.

Residents' associations choose an additional service from a local authority

Community representatives sit on Local Strategic Partnerships and help to influence priorities

Refuse collection—Local authorities may wish to offer the choice of additional collection services such as garden waste

In secondary health care, from 2005 patients will be able to express a choice from five hospitals on referral for elective surgery

Patients decide whether to access a GP, walk-in centre or NHS direct to meet their particular need

Direct payment schemes in community care allow users to spend their grant with the provider of their choice

Some social housing choice based lettings schemes operate in this way: registered social landlords and private landlords are contracted to the local housing authority to provide social housing

From whom do they choose?

A taxonomy of choice in the public services

How are they enabled to choose?

Preference

Private funds

Provider charges

Public funds allocations

Mixed funding

Non-financial allocations

Voucher

The provider

How the service is provided

Aspects of the service such as the timing, location or nature of the service provided

Description Example

A preference can be expressed within the existing capacity of public sector provision

Users use their own resources to purchase services outside the public sector

Users use their own resources to choose to purchase services which are charged by the public sector provider

Where public funding allows users to choose their provider and funding could vary depending on the needs of the user

Where public funding may be topped up by private contributions by the user, possibly depending on the income of the user

Where users are provided with resources other than money such as a priority related points allocation

Where users are provided with a sum of public funds in the form of a voucher to spend on the service provider of their choice

Choice between different providers of the same service

Choice between different ways of obtaining the service they require

Choice in the way services are accessed, for example to provide more flexibility to suit modern lifestyles

Right to express a preference in regard to secondary school allocation

Now exercised by some 6.8% of parents nationally in regard to secondary school

Local authority leisure services

Community care direct payments schemes in which local authorities make cash payments to individuals to purchase their own community care

Co-payment health schemes in United States of America

Points based allocation of social housing 1996 Pre-school education voucher scheme

Patients choose which Primary Care Trust contractor to register with

Patients choose between seeing their GP, seeking advice from NHS Direct or attending a walk-in centre

Primary care practices provide evening and week-end surgeries

What do they choose?

Source: National Audit Office

Annex B

SUMMARY OF RELEVANT FINDINGS AND RECOMMENDATIONS FROM RECENT NAO REPORTS COVERING CHOICE AND EQUITY ISSUES

NAO report
Summary of relevant findings
Summary of relevant recommendations

Early years: Progress in developing high quality childcare and early education accessible to all

HC 268 2003–04

Nearly 100,000 new childcare places have been created for pre-school children but more needs to be done to ensure that new provision is sustainable.

Less early years provision is available in deprived areas than in other areas.

Hip replacements: getting it right first time

HC 417, 1999–2000

One in seven parents said there was no local choice for their child and the NAO found that there is insufficient flexibility to meet the needs of some, especially lone parents, although the gap is narrowing.

Hip replacements: an update

HC 956, 2002–03

NHS patients were receiving an improved hip replacement service by the time the update report was published.

More still needed to be done to ensure better quality of care.

Ten per cent of consultants use replacement hips for which there is no adequate evidence that they are effective over the long term.

The average wait for surgery following an outpatient appointment is eight months, compared to a target maximum of 12 months.

Ten per cent of consultants believe that a quarter or more of GP referrals are inappropriate, imposing an unnecessary burden on patients and the NHS.

Ten per cent of consultants use waiting time targets, rather than the clinical need of each patient, to determine priorities between patients.

Expand provision where it is needed by focusing more on developing integrated provision and ensuring it is sustainable.

Improve sustainability by ensuring that parents have access to assistance in understanding their costs and planning for the future.

Reduce national variations in quality of care by developing an accepted integrated care pathway for hip replacement.

Inequalities and inconsistencies should be addressed so that all patients access services purely on the basis of need.

High quality information should be developed and provided to patients in a format they can understand.

NHS Direct in England HC 430 2002–03

Improving Social Housing Through Transfer HC 496 2002–03

Target effort at both a national and local level to reach those groups with lower than average awareness and/or usage—particularly younger people, older people, ethnic minority groups and less advantaged social groups.

Improve the ability of ethnic minority groups to make use of the service by providing suitable levels of support, in particular by employing more bilingual nurses.

Strengthen senior management to provide further direction, prioritisation and management. Be strategic and determine how the service relates to policy priorities elsewhere in the NHS.

Extend the range of choice of landlord, to achieve the best transfer terms for tenants at a reasonable price, and require clearer promises about the benefits tenants can expect from transfer.

Explore further how greater choice and competition can be brought to bear without undermining tenant support.

Incorporate learning on how to handle tenants' concerns in later transfers.

Processes need to be open and transparent so that tenants can have confidence in what they are deciding upon.

NHS Direct achieved a high level of customer satisfaction. Evidence suggests that it helps reduce demand on out of hours services and is directing callers to more appropriate forms of care during the day.

Not all social groups use NHS Direct equally. Younger people, people over 65, ethnic minority groups, more disadvantaged social groups and people with disabilities were either less aware of NHS Direct or used it less, despite needing the service as much or more than others.

According to NAO estimates, NHS Direct was off-setting around half of its running costs by encouraging more appropriate use of NHS services. NHS Direct also added value by reassuring callers and saving them unnecessary anxiety.

Transfer of housing stock was intended to bring forward the improvement of local authority housing and offer greater tenant choice and participation.

The transfer was achieved at an estimated cost of £1.3 billion over 30 years, although the department believed the benefits to tenants made this value for money.

Tenants were consulted about the transfer process and balloted about whether it should take place. Where a majority of tenants were opposed the transfer did not proceed.

Widening participation in higher education in England HC 485 2001–02

Improving Service Delivery: The Role of Executive Agencies HC 525 2002–03

Identify groups that need encouragement to apply and to ensure that applicants from groups with low representation receive fair treatment relative to others.

Provide comprehensive information on the nature of the course and the eventual destination of previous students taking the course.

When assessing such initiatives, agencies should explicitly take into account their likely impact on users and focus on aspects that deliver most benefit to users.

Services should implement a culture of delivery with a guiding ethos of customer-led service design and delivery within an overall framework of national standards, incentives and reward for effective frontline operations.

Women and ethnic minorities are well represented but participation levels are still low for people with disabilities and those from poorer social classes.

Costs of ensuring equity and widening participation are substantial but more systematic ways of determining the benefits should be implemented.

Agencies use a range of initiatives to evaluate and improve service delivery including seeking accreditation against external quality standards.

While agencies generally have systems in place for identifying and monitoring costs, these are not often linked to key outputs and outcomes. The pursuit of improved service delivery must be balanced by the need to provide value for money. Agencies need to adopt more sophisticated approaches to measuring costs and productivity.

Memorandum by the Business Services Association (CVP 13)

Introduction

BSA (the Business Services Association) is the advocate of major companies providing outsourced services in the UK, across Europe and world-wide. BSA's 20 members operate in the UK, across Europe and in more than 75 countries worldwide. They have a combined turnover in business-to-business services of £20 billion per annum and employ some 500,000 people in the UK. They currently provide services to 96 of the FTSE 100 top companies and at least 170 of the FTSE 250, and in the public sector they provide services to hospitals, defence establishments, schools and colleges and local authorities.

BSA has worked closely with Government to move forward the modernising agenda and strongly supports the concept of choice for the end-user of public services.

Defining What Choice Means in the Public Sector

The concept of choice for public service users goes far beyond the minimum rights and standards offered to them in the past. For choice to be meaningful, the end-users must have the ability to choose both the type and level of service they require and the provider of that service (whether from the public or the private sector).

Inevitably, the nature of that choice will vary to some extent depending on the type of service to be provided. In some cases, such as educational services, it may well be possible for the individual consumer to choose from a wide range of options across the state and private sectors. In others, especially areas where public health or safety may be involved such as the provision of police or fire services, a more restricted choice may be available and there will be a need for a local rather than an individual choice to be made.

The needs of the end-users have always been important but historically in the public sector they have not always been properly addressed, especially under the old competitive tendering regimes. Services were delivered in the way in which the authority had always provided them. Consumerism and the element of choice have had a radical effect on that approach. In the private sector too, clients sought the provision of services which they thought were best for those in receipt of them without consulting the users. That too has changed. Public services must be of a high quality if they are to satisfy end-users who have become seasoned consumers, willing to challenge standards which they do not believe are sufficiently high.

The Concept of Customers of Public Services

Choice is not simply about competitiveness or market mechanisms—these are issues for the client and not for the end-user. Rather, it is a shifting of the central focus from what the provider believes the end-user should have to a greater awareness of and responsiveness to the level and type of service which the client group itself requires.

Every member of the public is, to a greater or lesser extent, a consumer of public services, whether or not he is willing or able to be an "active citizen". Indeed, it may well be the case that those who participate least in the formal democratic process, including those from ethnic minority groups, are amongst the heaviest consumers of many public services.

Both active citizens and democratic accountability have a crucial role to play in ensuring that the aspirations of the end-user are met. Active participation by the individual citizen in the shaping of the services he wishes to see provided will ultimately affect the shape of wider service delivery. Democratic accountability will ensure that, if the aspirations of the individual and the community are not met, or the appropriate services are not provided to the required standards, the providers will be held to account.

While service providers welcome these developments, they have a knock-on effect for those who provide the services and must now add a new dimension into their processes. Knowing the needs and wishes of service users is not easy, since each group or individual will have a unique agenda. The art is in balancing these competing desires to satisfy as many as possible of these for as much of the time as possible. The wider the disparity in the user community, the more difficult the process becomes.

It is important to ensure that the appropriate mechanisms are put into place to enable all customers of public services to have an equal opportunity to make a genuine and informed choice. The system must not be allowed to favour those who are the most articulate and politically aware.

It would be helpful to have a clearer definition of who Government sees as the customer or user of each service, though in the majority of cases this will be a matter of common sense. In the example quoted, it does not seem practicable to allow the pupil to be responsible for the final decision, although it would seem desirable that he should have some voice in the decision-making process. A helpful distinction may be to see the parent as the customer and the child as the consumer.

In other cases, it may be argued that the customer is a group of people rather than a single individual, as for example in the case of local refuse collection, where the residents of a street or block of flats may be required to make a collective decision as to the service provider and the level and type of service.

The concept of a "customer" cannot be limited to public-facing activities, since services are provided for internal as well as external consumption, as for example in the outsourcing of buildings maintenance and other services to public sector establishments which in turn provide other services to the wider public.

Mechanisms for Expressing Choice

Targets and league tables have a role to play in the achievement and maintenance of standards of performance but they cannot ensure adequate responsiveness to consumer preferences. Indeed, they may militate against it by encouraging consumers to judge schools and hospitals only by league table success rather than by other criteria which might be more meaningful to the individual. Customer surveys and complaints systems have an important role to play, but need to be administered carefully to ensure that they are not biased in favour of the views of the more articulate consumers.

Individual choice, collective choice and choice on behalf of the citizen can and should co-exist in a genuine system of consumer choice. Each will be appropriate in different circumstances, but is it unlikely that all these forms of choice will be equally effective in ensuring efficiency, responsiveness, equity and fairness.

Choice on behalf of the citizen is the least likely to achieve responsiveness to local or individual needs, but the standards and systems which it imposes may be the best way of ensuring a coherent provision of key services such as policing. A national or regional system, if administered effectively, may also be the most efficient way of providing some services, though despite superficial appearances it will not necessarily be the most equitable, since the provision of the same service to all will not meet the needs of all equally.

Choice and the Public Good

The risk that a wholly consumerist approach to public services could undermine the public service ethos must be recognised. Ultimately it is the responsibility of Government and the public sector authorities to take the wider view which recognises that the most important factor is "the greatest good for the greatest number", even if this may in some situations restrict the freedom of choice of the individual.

Capacity in the Public Services

For choice to operate effectively, the capacity of public services to provide will undoubtedly need to increase. The increased pressure on the public sector providers will best be addressed by outsourcing much of this provision to the private sector. Private sector service providers are already well used to operating in a market which is driven by choice, and their expertise will be essential to the effective operation of choice-based public services.

Funding is crucial to the effective provision of choice, as customers must be confident that their chosen option is financially sustainable. Even if the funding for public services is provided nationally, it will be preferable for it to be administered locally to ensure proper responsiveness to local needs. There are clear cost implications in the extension of choice although these should not be seen as insurmountable. Private sector experience of cost containment can assist and PFI and other partnership models will provide the best solution in many cases.

The use of PFI and other forms of partnership with the private sector has the advantage of introducing a level of expertise from the private sector partner which might not otherwise be available, but the primary reason for the use of such models is predicated on cost containment and increased quality of service provision. PPPs have the ability to enable the public sector to provide services within agreed costs while also meeting the requirements of the customer and the demands of Government.

It should be noted that choice does have important implications for future outsourcing contracts, by increasing the level of risk involved. In order to offer choice to its customers, the public sector will need to take one of two courses, either specifying that the chosen contractor must provide a number of options from which the customer can select or, perhaps more likely, inviting a number of different contractors to provide services in a given field. In either case, the nature of the choice offered to customers means that the throughput per contractor cannot be guaranteed, with clear implications for the risk profile of the contract. This is an issue which Government will need to resolve in discussion with the private sector.

There should be no conflict between the establishment of an overall framework of uniform standards and the availability of choice to the end-user. Overall standards provide a framework for consistency, quality and fairness, but within this framework there will always be a requirement for flexibility in application if local needs and aspirations are to be met.

Raising Standards

Although there is a public perception that choice will benefit the more articulate middle-class consumer at the expense of the more socially disadvantaged, there is in reality a strong body of evidence which shows that choice drives up standards across the board by encouraging creative competition. A monopoly situation is in fact the least effective way to promote the delivery of quality services.

The changes in the Swedish schools system introduced in 1992, allowing parents to choose freely the type of schooling appropriate to their children, whether in the independent or state sector, provide a good example. Far from increasing the divide between "good" and "bad" or "popular" and "unpopular" schools, competition has driven up standards across state and independent schools alike. This contrasts starkly with the level of choice currently offered to UK parents, which is largely restricted by geographic criteria, often allocating places in a popular school only to those living within a restricted postcode area and favouring those families which can afford to move into the area in order to qualify for admission.

Evidence Base

A substantial body of evidence exists in the work undertaken by the National Audit Office, the Audit Commission and think-tanks such as ippr to indicate that a choice-driven structure can improve the level of service provision for all consumers. Clearly, as this way of procuring and providing services becomes more widespread, there will be a need for continued monitoring and research to ensure equity of service provision.

Conclusions

All of us as individuals use public services and we know what we want and expect. When this does not square with what we receive, we are disappointed. If private sector companies can bring to bear their international experience and expertise to assist their public sector clients in appropriate cases, we must remain resolutely committed to doing this for the greater good of our local communities and public services at large.

Public services are at the heart of every community. BSA members, both as individual users of these services and as service providers, are very aware of the importance of delivering high-quality services to every citizen. We believe that this will best be achieved by a flexible, choice-based approach which utilises the skills and expertise of the private sector in strategic partnership with the public sector client, and would welcome the opportunity to contribute further to this important debate.

April 2004

Memorandum by the London Borough of Camden (CVP 14)

Introduction

Camden welcomes PASC's interest in exploring the notion of choice in public services. At the national level, this debate is attracting much attention and comment at present, especially since it was highlighted by the Prime Minister as one of his four principles of public sector reform. The concept of "choice and voice" is also extremely pertinent at the local level, to the London Borough of Camden and all local authorities who deliver key public services such as housing, education, and social services and who work in partnership with a wide range of other public service providers, such as primary care trusts and mental health and social care trusts. Local authorities are big players in the public sector, accounting as they do for around 25% of public expenditure. They have an important community leadership role, as well as being a significant employer in the UK.

Based on its experience as a provider, coordinator and facilitator of a complex range of public services, Camden remains unconvinced that choice should be a fundamental principle of public service reform. The evidence base for the contribution of choice to improving public services, especially the merit of giving people a choice between providers, is weak. Recent MORI research in the UK indicates that whereas "choice" in public services is potentially popular, there comes a point where too much choice stops being perceived as beneficial to the customer. Much cited US research on choice (for example, by Schwartz) looking at products, brands and consumer options also indicates that it does not necessarily make people happy nor does it increase their quality of life.

Although research on consumer choice is thought provoking, to directly correlate it with choice in public services is unrealistic. In reality, the degree of choice that is desirable and sensible in public services will vary depending on a whole host of factors. For example, users of public services do not necessarily want to have to shop around and take a consumerist view during times when they may be especially vulnerable through illness, infirmity and other challenging life events. In all circumstances, but particularly when dealing either with medical or statutory services (such as social services or the criminal justice system) we would argue that the quality of the interaction between the service user and the staff providing the service is far more important to get right than offering a choice of provider. We believe that tailoring the service to suit the needs of the individual at the time—rather than worrying about whether they could choose who provides it—is far more important as a way of improving public services.

In our role as the local tier of government, a point we would also make is that political choice, and choice made through democratic representatives, need to feature in this debate as well. Governance of public services means reconciling many interests, and diverse and potentially conflicting individual choices.

The comments below address some but not all of the Committee's specific questions and our points are illustrated with examples where relevant.

Defining What Choice Means in the Public Sector

We feel clear definitions would be useful, but may be hard to achieve. In terms of individuals and their local authority, choice can mean a wide range of different things. For example, choice of providers (like a tenants' ballot on who their landlord should be); a consumer choice (whether to use the local public swimming pool or not, or private alternatives); a choice of schools but within limits of practicalities, admission criteria etc as well as the levels of information and assertiveness of parents; or tailored options of intensive care or support services including direct payments for buying services.

There are many positive uses of choice and customer-orientation in relation to council services and Government should recognise that the debate has long since moved on from "you can have any colour front door you like as long as it is council green". It is of concern that some senior figures imagine local authorities still to be in such a paradigm. We have already become much more responsive to preference and treat people more as if they were customers even in those services where they do not have alternatives, or their contact is involuntary. For example, Camden is a member of the Home Connections Choice-Based Lettings (CBL) service, covering six London boroughs and five housing associations. Here, choice is defined primarily as delegating decisions, previously made by the council or landlord, to the customer. A significant element of power and control has been handed over to the home seeker. Importantly this allows the customer to choose not to make a bid as well as to make a positive decision to bid for a home. And a choice not to make a bid for a particular property does not prejudice the customer's chances of successfully bidding for another property at a future time.

There is also, with CBL, a limited degree of choice of provider—council or housing association homes. Home seekers are increasingly offered a greater choice of location—both within a borough's boundaries and across London as we experiment with more cross-borough lettings. Camden also offers home seekers assisted opportunities to rent or buy in the private sector. We have used CBL to promote our Housing Options service that includes grants to help people buy a home if they vacate their existing Council home and rent in advance and a deposit if they are homeless. Other aspects of choice in using the service are the convenience offered by a 24x7 service, multilingual information channels and the choice of channel itself.

Choice and Equity

It should be recognised that the full market model cannot apply to public services. The concept of a "customer" does not adequately define the nature of the relationship and we should take care before we too readily transpose such a private-sector notion on to public services. One important factor is that choice in the private sector works both ways—providers choose their customers as much as consumers choose products or services. Public services cannot choose users in the same way. Even if we substitute public satisfaction or public benefit for the bottom-line profit measure, we cannot only serve customers who are more easily satisfied or cherry pick children who will achieve good exam results. We also often find ourselves "demarketing" services or scarce resources such as housing, rather than aiming to increase take-up or customer numbers.

For a diverse, inner-London Borough such as Camden, increasing social inclusion and tackling inequalities are at the heart of everything we do. The big questions are about deciding where and for which services we should develop more choice (of provider, of means of delivery, of levels and type of service, of opt out or vouchers, of extra service for extra payment). We recognise that in some services, individual choice may not be the key issue—what is more important is equality of standards, availability, supply, care, tailoring, and the greater public good. Individual choices cannot necessarily be relied on to promote community cohesion and equity. These decisions rest on questions of leadership, long-term thinking (for example balancing sustainability with immediate consumer demands), and efficiency and extra capacity.

Voice and Public Services

Local government uses a whole range of mechanisms to increase people's sense of agency and empowerment in their interaction with services. Direct payments in social services provide one example of co-production, which enables users to choose and take control of the care provided to them in their homes. Family group conferences in social services provide a further example of users working together with professionals to seek joint and workable solutions to problems. In housing, the choice-based lettings scheme similarly allows service users to behave more like consumers and we know they relish the opportunity to make choices previously decided by gatekeepers.

With regard to more traditional methods of "voicing" opinions on services, local authorities, including Camden, have gone far beyond complaints systems to much more sophisticated ways to find out people's preferences and needs. Polling, qualitative and deliberative techniques are all used to test what matters to people, perceptions of service quality, customer care and so on. In Camden we are about to launch a new Citizens' Panel which will offer many different opportunities to feed in views or get more actively involved, in a variety of ways. We have also recently consulted very extensively on a children and young people's strategy, which means that our partnership work in this area is very closely aligned to what young people see as important.

Devolution and Diversity

The nature of collective, representative and individual choice is another important dimension.

In terms of direct participation in services and how they are governed and designed, it is true that the ballot box is a blunt instrument to gauge support for the direction and priorities of all individual public services. Other ways to involve, consult and to encourage participation must be developed, and as cited above, we are doing a great deal of that. But there must still be scope to expose different approaches to service delivery and to local priorities to the vote. This is where local autonomy comes in, and it cannot be argued away because of post code lottery issues. There should be national minimum standards but then Government needs to let go, so that services can be more diverse and people can choose difference.

A particularly striking example of the limitations of choice in Camden, exercised through the ballot box, is Camden tenants' decision in January 2004 to reject an Arm's Length Management Organisation (ALMO) to manage its housing stock. This has left the Council with a £283 million funding gap and little hope of achieving the Government's Decent Homes Target by 2010. The current position is that Camden is a Council with a three-star housing management service (as rated by the Audit Commission's Housing Inspectorate) which will have to scale down its capacity and will be unable to invest in the necessary internal and external works to meet the Government's target. The rigidity of ODPM's housing policy, which will not allow funding flexibility for high performing local authority housing departments (except via the PFI, ALMO or stock transfer routes), sits uneasily with the principles of choice and diversity which are concurrently being espoused by No 10. Camden is, of course, working proactively and co-operatively with the Government to think through this dilemma. But a dilemma it most certainly is and our housing need remains as great as ever.

Capacity in the Public Services

For some services, there is a real balance to be struck between cost and offering choice. For example, efficiency gains through the growing number of e-government channels are hampered by the need to maintain traditional channels at the same time. We cannot apply the internet banking business model to our services, although we can develop new channels and encourage more people to use them over time.

Public expectations are high, and can be summed up as wanting tailored, responsive services but at mass-produced prices in terms of taxation. This is a challenge.

London's lack of public sector housing and affordable homes also present a capacity problem which acts as a severe constraint to the exercise of choice. For example, approximately 14,000 applicants are on Camden's housing waiting list, of whom about 4,000 actively chase around 1,400 annual vacancies in Camden—with the latter figure set to continue its decline as a consequence of people exercising their right to buy. Camden's annual residents' survey for 2004 confirms this worrying trend in housing market capacity. Significant increases in concern were registered in the last year about lack of affordable housing (up 5% this

year). Tellingly, there was more concern in Camden than London wide about homelessness and lack of affordable housing and less concern about the level of Council Tax, traffic congestion and the health service. This is stark evidence of a rising problem for Camden, and the whole of London and the South East.

Councillor Dame Jane Roberts
Leader of the Council

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