



House of Commons  
Public Administration  
Select Committee

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# **Choice, Voice and Public Services**

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**Fourth Report of Session 2004–05**

*Volume I*





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***Volume I***

*Report, together with formal minutes*

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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.

### Current membership

Tony Wright MP (*Labour, Cannock Chase*) (Chairman)  
Annette Brooke MP (*Liberal Democrat, Mid Dorset and Poole North*)  
Mrs Anne Campbell MP (*Labour, Cambridge*)  
Sir Sydney Chapman MP (*Conservative, Chipping Barnet*)  
Mr David Heyes MP (*Labour, Ashton under Lyne*)  
Mr Kelvin Hopkins MP (*Labour, Luton North*)  
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Mr Gordon Prentice MP (*Labour, Pendle*)  
Hon Michael Trend, CBE MP (*Conservative, Windsor*)  
Brian White MP (*Labour, Milton Keynes North East*)  
Iain Wright MP (*Labour, Hartlepool*)

The following member was also a member of the committee during the inquiry.

Mr Kevin Brennan MP (*Labour, Cardiff West*)

### Powers

The committee is one of the select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 146. These are available on the Internet via [www.parliament.uk](http://www.parliament.uk).

### Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at [www.parliament.uk/parliamentary\\_committees/public\\_administration\\_select\\_committee.cfm](http://www.parliament.uk/parliamentary_committees/public_administration_select_committee.cfm). A list of Reports of the Committee in the present Parliament is at the back of this volume.

### Committee staff

The current staff of the Committee are Philip Aylett (Clerk), Clive Porro (Second Clerk), Lucinda Maer (Committee Specialist), Jackie Recardo (Committee Assistant), Jenny Pickard (Committee Secretary) and Phil Jones (Senior Office Clerk).

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## Summary

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This Report assesses the effectiveness of the Government's plans for giving service users both more choice over the services they use, and more say about the way that services are provided. In particular, the Committee looks at the extent to which policies in the fields of health care, education and social housing give service users more power and control over the services they use, and the ways in which public services could become more responsive to those that use them.

We welcome the Government's ambition for responsive, user-focused public services. We conclude that choice and voice mechanisms can, and should, be combined to ensure that this happens. The Government has done much to promote the notion of choice and has given some consideration to ways in which users can participate more actively in decisions affecting their local services. However, there is still some way to go to ensure both mechanisms deliver, especially for those who are less articulate and more vulnerable and hence have a greater dependency on effective public services.

Although a number of pilots, particularly in the health service, have shown encouraging results, it is too early to say whether choice, especially wider choice of service provider, will provide the benefits of greater efficiency, higher standards and better performance which its supporters claim for it.

In particular, we found that the rhetoric about choice can exceed its reality. Matching patients on waiting lists with available places in hospitals, for example, is as much about planning as about choices made by individuals. More than this, the tendency to apply the labels of choice to schemes and services such as school preferences, where the first choice option may be unattainable for many, only creates disappointment and disillusionment with what often are perfectly good second or third choices.

Our evidence also revealed that, while choice matters to people, it is not necessarily their highest priority when it comes to public services. The choice that often matters most to those who are more reliant on the provision of good local services is the ability to make decisions which have a direct and immediate impact on the quality of their lives. The popularity of schemes such as direct payments for social care or active management of their treatment by patients with chronic illness show that users value the ability to exercise control and greater power over their lives regardless of who provides the service.

Our Report also makes it clear that if choice is to succeed it will have implications for the Government's wider objective of containing costs and increasing the efficiency of the public sector. For choice to be effective we found it was necessary to ensure additional capacity in the appropriate places. This not only comes at a cost, but expanding a successful school or closing a hospital cannot be an immediate, or even a practical, response to user choice. We therefore encourage the Government to consider other approaches to improve performance, including collaboration between providers to ensure good quality, local services.

The argument that widening provision is the first step to privatisation has not been proven. However, we did find a high risk that the introduction of alternative providers can generate

additional costs and the creaming-off of less difficult cases. We urge ministers to ensure that the private sector do not exploit choice schemes to the detriment of the public interest. We conclude that expanding choice and increasing the number of providers can be consistent with maintaining equity, but only if choice schemes are well-designed and start with the specific goal of reducing unfairness. We suggest a number of initiatives of this kind.

The Report also finds that the Government has been equivocal about its intentions on engaging the users of local services. There has been positive support in the form of the establishment of Foundation Trusts and, most recently, the Office of the Deputy Prime Minister's ideas for greater local engagement in decision making. On the other hand, in certain areas such as Sure Start, the Government's enthusiasm for wider public engagement seems to have cooled.

Moreover, established methods of recording user satisfaction, handling complaints and offering redress are far from satisfactory. More care and more imaginative consideration need to be given to making such 'voice' mechanisms more effective. We therefore propose the development of a measurable and comprehensible Public Satisfaction Index.

Finally, we conclude that if users of public services are to have the right to choose the sort of service they want and to have their views heard, they should also have the right to expect a guaranteed minimum level of service. A choice between several poor schools or hospitals is no real choice at all. We commend the idea of 'Public Service Guarantees' which build on service standards schemes, such as the Charter Mark, which already exist. Public Service Guarantees would articulate the expectation of good customer service and provide the means to ensure that they are met by providers. They should be robustly, and where necessary, jointly monitored against agreed levels of performance by the existing national and local watchdogs, working cohesively in a strategic alliance.

# 1 The Context: Choice, Voice and Public Service Reform

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1. This Report assesses two key aspects of the Government's programme for public service reform—its policies on choice and voice. It is the product of an inquiry that began in the Spring of 2004 with the publication by the Committee of an Issues and Questions Paper seeking written evidence on some of the main themes. This was followed by a round-table discussion with advocates and critics of choice-based policies which allowed the Committee to draw out issues for the inquiry. The National Audit Office (NAO) carried out some qualitative and quantitative research for the Committee on the operation of choice-based policies and public attitudes to choice in Birmingham. We also visited a school, the City Council and a primary care trust in Birmingham during January 2005, when we also took formal oral evidence. This visit, along with one to Washington and North Carolina in April 2004, gave us an invaluable insight into the place of choice and voice in the lives of those who use and provide a range of public services. In total, the Committee received 25 written memoranda and took oral evidence from a total of 30 witnesses, including three ministers, over six sessions.

2. The historical context for the current debate on public service reform goes back at least as far as the creation of the modern welfare state in the years after 1945. This saw the establishment of a broad and long-lasting consensus that whole areas of activity, previously in the private sector, should now be regulated or directly owned by the state in the public interest to secure both efficiency and equity. The most notable achievement was, of course, the creation of the National Health Service. The 1970s, however, began to see a breakdown of this consensus. This was followed in the 1980s by a determined attempt by government to withdraw from some large areas of state control or intervention, and the development of a more market-led approach in others.

3. Variations to the post-war model of provision of public services have tended to involve either target-setting, benchmarking and performance-related pay; or competitive tendering and external contracting for defined, often stand-alone, services ranging from cleaning to IT. Both of these approaches are now well established as part of public service reform. The Committee has in the past few years examined many aspects of this reform, including the culture of performance targets and league tables.<sup>1</sup>

4. The third variant, less developed but increasingly important in the debate on the public services, is choice, often defined as giving individuals the opportunity to choose from among alternative suppliers, whether or not entirely within the public sector. Another approach, also prominent in recent years, is to give users a more effective say in the direction of services, by means of representative bodies, complaints mechanisms and surveys of individual preferences and views—in short, to give users a stronger “voice”.

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<sup>1</sup> Public Administration Select Committee, Fifth Report of Session 2002–03, *On Target? Government by Measurement*, HC 62-I

## Our approach: putting the user in charge

5. In this Report we assess the effectiveness of the Government's plans for choice and voice in public services using a straightforward test: to what extent do their policies give people greater control and power over the services they use? It is only by making services responsive that such power and control will pass from the provider to the user, and to the citizen. Peter Hay, Strategic Director, Social Care and Health Directorate, Birmingham City Council, summarised this very well when he gave evidence to us during our visit to the city. Asked what vulnerable people in social care really wanted from their services, he said that they especially valued:

“being more in charge—I am not sure it is necessarily choice, but certainly control is the important bit. Most users talk about being more in control of the arrangements in their lives than making a choice, because most of them would choose not to be in that situation”.<sup>2</sup>

6. We examined in particular detail three services where the debate on choice is especially lively—health, secondary education and social housing—but we believe that much of our analysis can also be applied more widely. Our intention throughout is to identify themes which are common to a number of public services, although some of our recommendations will have special application in particular fields. In the next chapter we describe in more detail the Government's plans to introduce more choice and voice in public services.

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<sup>2</sup> Q 387 [Hay]

## 2 The Government's plans for choice and voice in public services

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### The background

7. This chapter outlines the background to the Government's existing programmes and plans for the future of choice and voice in public services. It describes two main types of public service choice: one in which users are offered a choice of "provider" (for instance a choice between hospitals or schools) and the other where choices are offered without any option as to the provider (what has been called "choice from variety", which might include choice of school subject or medical treatment). We also outline the Government's plans to give people a more active say in the running of services—what is usually called "voice".

8. Governments have for some time promised greater choice for those who use public services. But in recent years the idea of choice has begun to play a far more prominent role in the debate on public service reform. The notion of minimum rights for service users was set out in detail for the first time under the Major administration in the Citizen's Charter of the early 1990s. However, it was after the election of the present Government in 1997 that the idea of users also being given choices as consumers of public services gained greater currency. In March 1999 the Modernising Government White Paper set out Ministers' plans for reforming the machinery of government. One of the White Paper's five commitments was to increase the responsiveness of public services to make them meet the needs of citizens rather than the convenience of service providers. The document declared that:

"People are exercising choice and demanding higher quality. In the private sector, services 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".<sup>3</sup>

9. In 2001, the Prime Minister said that "the key to reform is redesigning the services around the user—the patient, the pupil, the passenger, the victim of crime".<sup>4</sup> He went on to outline four key principles of public service reform: national standards and accountability; devolution to the frontline; diversity and promotion of alternative providers; and greater choice.

10. In a series of Government policy announcements in June 2004, choice appeared yet more prominently as the central tenet of public service reform. Five year plans on health and education both outlined ways in which services were to be made more responsive to users, with more choices being built in. The Prime Minister told his monthly press conference:

"what we are trying to do with the public services is to change monolithic services into services which are far more centred around the user of those services, which are

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<sup>3</sup> Cabinet Office, *Modernising Government White Paper*, Cm 4331, 1999, para 9

<sup>4</sup> Prime Minister's Speech on Public Service Reform, 16 October 2001

more diverse in their supply, which ensure that if people are getting a bad system that they have got the ability to go elsewhere”.<sup>5</sup>

### Choice of provider

11. There are many categories of choice, but the schemes that have been most widely debated and most contested have been intended to give patients, parents and tenants a choice of service provider. These schemes for **choice of provider** in Britain have tended to be:

- introduced across the whole country;
- highly publicised;
- the cause of widespread ideological and/or political debate;
- based at least partly on greater use of private or voluntary sector providers; and
- intended to offer single and fairly straightforward choices, often for those who do not make heavy and repeated use of complex and multiple public services.

12. We now examine in more detail a number of such schemes.

### Choice of secondary school

13. A great deal of choice is already, in theory, available to parents of children who are moving on to secondary education. The 1944 Education Act introduced a requirement for local authorities to have regard to parental choice in secondary education. This right has been central to legislation in succeeding years, including the 1988 Education Act which extended choice by widening the scope of parental preference beyond the boundaries of the child’s home Local Education Authority.

14. However, the right to express a preference for a school does not mean that the child is guaranteed a place at the preferred school. If a parent applies to a school and there is room, he or she must be offered a place (unless, for example, it is a specialist school and the child does not meet the requirement). If, however, there are more applicants than places, the admissions authority will use “oversubscription” criteria to decide which pupil should be offered a place. These criteria are published each year by the admission authority (which is either the Local Education Authority or the school itself if the school is voluntary-aided). Some commonly used criteria include: whether the child has a sibling already at that school; whether the child lives in the catchment area of the school; and whether the child and his or her family is of a particular faith. If a child fails to get into a school of his or her choice they have a right to appeal to an independent appeals panel. A further right of appeal, to the Local Government Ombudsman, also exists. There is in addition the Schools Adjudicator, to whom parents can appeal if they object to the published admissions arrangements.

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<sup>5</sup> Prime Minister’s Press Conference, 15 June 2004

15. Some changes are now being made to the arrangements by which secondary school places are decided, with the intention of reducing or removing parents' opportunities for manipulating the system to their advantage. At present parents may make applications to schools in more than one admission authority, and may therefore receive more than one offer of a place for their child. From the applications round in 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, regardless of where they are situated. The local education authority will act as a clearing house and notify the admission authorities of the school to which an application had been made. The admission authority will notify the local education authority about whether the child 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.

16. In another move towards wider choice, the Government is committed to increasing diversity in the types of secondary schools, with a substantial growth in the number of specialist schools and academies. Almost two-thirds of secondary schools already have specialist status. There is also to be increased freedom for all secondary schools to own their own buildings, manage their assets, employ their staff and engage outside partners. Schools will find it easier to expand and it will become easier to establish new schools. The long term aim is to establish a system that gives "every parent and pupil the choice of an excellent education".<sup>6</sup> As Dr Philip Hunter, the Chief Schools Adjudicator, said, "There is now far more for parents to choose from. All political parties are keen to develop schools that pupils, parents and staff perceive as tailor-made for them".<sup>7</sup>

### **Choice of healthcare provider**

17. In this section we concentrate in particular on patients' choice of hospital for surgery and other treatment. At one time there was a strong tradition of choice of provider in the NHS. Professor Allyson Pollock of University College London explained that:

"until 1991 there was extraordinary choice in terms of providers. All patients were entitled to second or third opinions, and to go to the provider of choice".<sup>8</sup>

18. However, a series of NHS reforms, including the development in the late 1980s and early 1990s of the internal market, as the NAO told the Committee, "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 to whom they could refer their patients, although the Patient's Charter did provide for the right to be referred 'to a consultant acceptable [to you]'.<sup>9</sup> The internal market was abolished in the late 1990s by the new administration, which then went on to create Primary Care Trusts to act as the main commissioners of hospital services.

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<sup>6</sup> Department for Education and Skills, *Five Year Strategy for Children and Learners*, Cm 6272, July 2004

<sup>7</sup> Philip Hunter, "Schools: more options: less choice", *The Guardian*, 9 March 2004

<sup>8</sup> Q167

<sup>9</sup> CVP 12, para 30

19. At the beginning of the current century the idea of choice began to move to the forefront of the NHS debate. The Patient Choice scheme in coronary heart disease was introduced on 1 July 2002 as a national pilot. Under this scheme, a patient who has been on a waiting list for a heart operation for six months is offered the choice of remaining on the waiting list of the same hospital until an appointment becomes available, or transferring to the list at another hospital where he or she can be treated sooner.

20. A similar scheme, the London Patient Choice Project, was established in October 2002 to increase the options for patients who are clinically eligible for elective treatment and who have been waiting for treatment at an NHS London hospital for some time. The scheme currently covers orthopaedics, ear nose and throat, general surgery and urology procedures. Beginning in July 2004, the scheme has also included a number of projects which offer choice at the point of referral, which avoids the need to be on a waiting list for six months. The London scheme has to date offered choice to 18,427 patients, and has had an encouraging overall take-up rate of 66%.

21. The Government announced a timetable for expanding patient choice:

- From August 2004, patients waiting more than six months for elective surgery are offered faster treatment at an alternative hospital;
- From January 2005, patients requiring cataract surgery (including those referred directly by an optometrist) are offered a choice of hospital at the time they are referred for treatment;
- From April 2005, patients who need a heart operation will be offered a choice of hospital at the time they are referred for treatment;
- By December 2005, patients who require an elective referral will be offered a choice of 4-5 hospitals (or suitable alternative providers) and a choice of time and date for the booked appointment, at the time they are referred by their GP or primary care professional.<sup>11</sup> The range of service providers would include independent sector hospitals as well as NHS and Foundation Trusts.

22. In order to allow fair comparisons between providers, and to ensure that money follows the patient when they have made a choice, a system known as Payment by Results (PbR) has been established under the NHS reforms. This means that purchasers (normally Primary Care Trusts) will increasingly pay hospital trusts and other providers for the exact amount of activity that they undertake, instead of paying through block agreements. The new payments are adjusted for “casemix”—the difficulty and complexity of the procedures involved.

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<sup>11</sup> Department of Health, “Choose and Book”—Patients Choice of Hospital and Booked Appointment: Policy framework for choice and booking at the point of referral, August 2004

### **Choice of manager of social housing stock**

23. There have also been moves to extend choice of provider in the field of social housing. All homes in the social housing sector have to comply with the Decent Homes standard by 2010, as first set out by the Housing Green Paper of April 2000.<sup>12</sup> Since 2001, the Government has refused to provide specific funding for the achievement of the Decent Homes target for stock retained under the management of local authorities. Unless local authorities are able to fund the achievement of the Decent Homes target out of their existing funding streams, they have a number of options, which all entail moving the ownership or management of the housing stock partly or wholly out of council control: stock transfer to a registered social landlord, the establishment of an arm's length management organisation (ALMO), or the creation of a Private Finance Initiative (PFI) scheme. In the latter two cases, the council retains the management of the housing stock, though these schemes are only available to high performing councils. All local authorities are obliged to carry out a thorough options appraisal and have it approved by the Government Office in their region no later than July 2005.

### **Direct payments for social care**

24. Direct payments enable individuals to choose to purchase social care from a number of providers, rather than the council choosing a provider for all their residents. Direct payments allow individuals to purchase services from their own support workers, sometimes called personal assistants. This means that individual direct payments recipients can become employers. According to the Department of Health website "Giving money in place of social care services means people have greater choice and control over their lives, and are able to make their own decisions about how care is delivered".<sup>13</sup>

25. The scheme began as an option for councils, but from April 2003 local authorities have been required to offer direct payments to all eligible individuals (disabled people aged 16 or over, to people with parental responsibility for disabled children and to carers aged 16 or over in respect of carer services). Following the April 2003 policy change, figures for take-up rose considerably from 9,300 adults aged 18 and over in 2002–03 to 17,000 during 2003–04. The National Consumer Council's Independent Commission on Public Services praised the direct payments system for improving accountability and promoting independence.<sup>14</sup>

### **Choice from variety: some alternative dimensions**

26. But choice of provider is only one of the many choices that are or might be made available to users of public services. The Government memorandum produced for this inquiry acknowledges that "giving a choice of provider is not always practical or desirable,

<sup>12</sup> Department for Environment Transport and the Regions, *Quality and Choice: A Decent Home for All—The Housing Green Paper*, April 2000. The Government defines a decent home as being "warm, waterproof" and with "reasonably modern facilities". The ODPM's PSA target 7 for the 2004 Spending Review is "By 2010, bring all social housing into a decent condition with most of this improvement taking place in deprived areas, and for vulnerable households in the private sector, including families with children, increase the proportion who live in homes that are in decent condition."

<sup>13</sup> [www.dh.gov.uk](http://www.dh.gov.uk)

<sup>14</sup> The National Consumer Council's Policy Commission on Public Services, *Making Public Services Personal: A new compact for public services* (London, 2004), p 45

and examples from local government demonstrate that the alternative dimensions of choice can also provide positive outcomes for users”.<sup>15</sup> The Local Government Information Unit categorised these alternative choices as ‘choosing from variety’:

“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”.<sup>16</sup>

27. Some of these schemes identified as “**choice from variety**”, where choice of provider is not offered, enjoy a warm welcome among professionals and among users. In this respect, their reception is sometimes in contrast to the unsympathetic response to some schemes which offer a choice of provider. This is perhaps because schemes offering choice from variety tend to be significantly different from those offering choice of provider:

- often, though not invariably, small-scale and local;
- based on the use of existing providers, overwhelmingly in the public sector;
- not very highly publicised;
- long-term; and
- intended for heavy users of (often multiple) public services.

28. We examine below a number of programmes which have been introduced by Ministers with the aim of offering greater choice from variety, an approach which has clear similarities to what the Government has described as “personalisation”.<sup>17</sup>

### **Personalised learning**

29. The Government has, for instance, recognised that schools need to adapt more effectively to the requirements of individual students. The former Schools Minister, David Miliband MP, has said:

“...we need to embrace individual empowerment within as well as between schools. This leads straight to the promise of personalised learning. It means building the organisation of schooling around the needs, interests and aptitudes of individual pupils; it makes shaping teaching around the way different youngsters learn; it means taking the case to nurture the unique talents of every pupil”.<sup>18</sup>

30. As part of the Government’s “personalised learning agenda”, all schools are encouraged to hold reviews with pupils at the end of Key Stage 3 (age 14) that leads to the development of an individual learning plan.

<sup>15</sup> CVP 24

<sup>16</sup> CVP 06

<sup>17</sup> See, for instance, Speech by Gordon Brown MP, Chancellor of the Exchequer, at an SMF reception to launch the publication of his lecture ‘A modern agenda for prosperity and social reform’, 18 May 2004

<sup>18</sup> Speech by David Miliband MP, *Choice and voice in personalised learning*, DfES Innovation Unit/ Demos/ OECD Conference, 18 May 2004

### **Expert Patients Programme**

31. Although such “personalised” services are planned largely by professionals and provided to patients or clients, other approaches go further, offering users the chance to build up the skills to design their own services and to have an active role in working out how they are managed. The Expert Patients Programme (EPP), for example, is a Government initiative which appears to offer more real choice to patients. This is an NHS-based training programme that provides the opportunity for people who live with long-term chronic conditions to develop new skills to manage their condition better on a day-to-day basis. Set up in April 2002, it is based on research which suggests that “people living with chronic illnesses are often in the best position to know what they need in managing their own condition. Provided with the necessary ‘self-management’ skills, they can make a tangible impact on their disease and quality of life more generally”.<sup>19</sup>

32. Pilot EPP courses began in 2002, and by May 2004 about 300 Primary Care Trusts had either implemented pilot courses or had committed themselves to joining. The NHS estimates that up to 19,000 patients will have benefited from this series of pilots by the time they finish.

### **Choice-based letting**

33. Traditionally, social housing in the UK has been allocated by housing officers on the basis of the comparative needs of those applying for housing. The Government has judged that this approach offers too little choice for tenants. A new choice-based lettings (CBL) pilot scheme began to operate in April 2001 following the April 2000 Green Paper ‘Quality and Opportunity for All’. A programme of 27 CBL pilots was supported with £13m from the Office of the Deputy Prime Minister (ODPM), with the aim of testing different approaches to providing choice in different contexts. The most popular model of choice-based lettings in the UK is based on the Delft system which has been in operation in the Netherlands for over ten years. This involves giving the prospective tenants, rather than a housing officer, the decision as to whether to apply for a property. The Government now plans that all local authorities should have introduced schemes for CBL by 2010.

### **When provider choice may not be appropriate**

34. Although choice can be valuable in giving users more power and control, we also recognise that it is not appropriate for every public service. Many services, especially those intended for the most vulnerable, are inherently sensitive, and we heard evidence of the difficulty of introducing greater choice in those services. For instance, the Sainsbury Centre for Mental Health demonstrated clearly that wider choice in mental health services could prove difficult to deliver:

“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;

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<sup>19</sup> NHS Website—[www.expertpatients.nhs.uk](http://www.expertpatients.nhs.uk)

- most services are organised geographically—community services are limited to specific areas so choosing between them is not an option”.<sup>20</sup>

35. The Centre pointed out that the “episodic nature” of many mental illnesses meant that patients were sometimes incapable of making choices because of their condition, while at other times they were perfectly able to consider the options. Moreover, in complex services working with scarce resources, one person’s choice can be another’s shortage, as the Democratic Health Network argued:

“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”.<sup>21</sup>

36. Some public services are inevitably collective in nature and therefore not well-suited to schemes to increase individual choice. It is evident that people are not able to choose what police force, or army, to use. As the Local Government Information Unit pointed out:

“Many public services are imposed, not chosen. Arrest, being put on the ‘at risk’ register, or receiving a parking ticket are never choices ... 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”.<sup>22</sup>

## The role of “voice”

37. In any case, wider choice is only one aspect of the policy of reform. The Government has come to believe that greater involvement by individual citizens in public bodies is also needed if public services are to improve. Effective representative institutions, complaints systems and user surveys—all mechanisms for giving users a “voice”—are also necessary to maintain services that respond to changes in the needs and preferences of users.

38. The Chancellor of the Duchy of Lancaster, Rt Hon Alan Milburn MP, explained the background in December 2004:

“reinventing government means reinventing the relationship between the state, services and citizens. It is time to take politics out of Whitehall, even beyond the town hall—to reconnect politics and the public where it counts most—in local communities”.<sup>23</sup>

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<sup>20</sup> CVP 01

<sup>21</sup> CVP 03

<sup>22</sup> CVP 06

<sup>23</sup> Rt Hon Alan Milburn MP, *‘Power to the people’: The modern route to social justice*, Speech to the Social Market Foundation, 8 December 2004

39. Referring to the falling turnout in elections, Mr Milburn identified an underlying democratic weakness “the public is not so much turned off by politics, as the way politics is done. Or for that matter, the way public services are run. Too often we shut people out when we should be letting them in”.<sup>24</sup>

40. The Government clearly values the power and control that choice can give the service user who may be frustrated by the lack of a proper voice. For the NHS, Rt Hon John Hutton MP, Minister of State for Health, made the case for choice and voice to work together to bring better NHS services. He argued that giving service users a voice without allowing them to exit the service and choose another limited the effectiveness of voice:

“Fundamentally as a health consumer, if you are not happy with the service you are getting and you have made all the complaints, you have only got that one service to use at the moment have you not? You cannot go anywhere else because your care is not going to be funded by any other part of the NHS. That is an utterly hopeless position to be in. That is why ultimately we must get the complaints procedure right, we must deal with the second stage processes efficiently as well. We need to do more on that”.<sup>25</sup>

41. Ministers have also made the complementary point that choice without “voice” is much less effective. As David Miliband MP, when Schools Minister, said “choice and voice are strengthened by the presence of each other: the threat of exit makes companies and parties listen; the ability to make your voice heard provides a tool to the consumer who does not want to change shops, or political parties, every time they are unhappy”.<sup>26</sup>

### ***The Government’s plans: more voice for the user***

42. The Government has recently begun to flesh out its broad statements on user voice with some more detailed proposals. To help correct the shortfall in democratic involvement he describes, Mr Milburn makes it clear that “giving individual citizens more information and more choice” is critical to reform, and puts particular stress on what he called “new mechanisms... for empowerment”. These include citizens’ juries and community surveys, but also new bodies aimed at shifting accountability “outwards and downwards”. Neighbourhood-level decision-making as part of the New Deal for Communities scheme is seen as a pioneer, but other similar moves in building up local decision-making bodies to help fight crime and poor urban environments are being developed. Mr Milburn also applauds more radical innovations in cities in Brazil and the USA, which give people direct control over their neighbourhood’s budgets and services. He comments “the results are impressive—both for public engagement, and service improvement”.<sup>27</sup>

43. These statements have been followed by the publication of the ODPM’s Five Year plan, along with two papers ‘Citizen Engagement and Public Services: Why neighbourhoods

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<sup>24</sup> *Ibid.*

<sup>25</sup> Q 470

<sup>26</sup> David Miliband MP, Speech, 18 May 2004

<sup>27</sup> Rt Hon Alan Milburn MP, Speech, 8 December 2004

matter’ and ‘Vibrant Local Leadership’.<sup>28</sup> Together they set out a number of proposals for involving communities more effectively in decision making. There are proposals for Neighbourhood Charters which set out standards of the services which local people can expect, and the control or influence that local people would exercise over these services. This might include giving local people the power to require action if the quality of service they receive falls below minimum standards, delegating budgets to ward councillors, who would be encouraged to take on a greater community advocacy and leadership role, and giving communities ownership of local assets.

44. Whilst the Government is planning to allow local authorities to devolve power to communities and small, very local neighbourhoods, a number of measures are also being taken to bolster traditional local government. The Government is revisiting the use of directly elected mayors to provide leadership for local government. It is also proposing to accept a recommendation of the Electoral Commission which aims to make democratic structures easier to understand by moving to all-out election for all councils in England every four years, in place of the present system of staggered elections. Local councillors are to be encouraged to be effective advocates and leaders for wards and neighbourhoods, and should be “at the heart of neighbourhood arrangements, stimulating the local voice, listening to it, and representing it at local level”.<sup>29</sup> The Government states that:

“One of the key principles for greater neighbourhood engagement is that neighbourhood arrangements must be consistent with a local representative democracy that gives legitimacy to governmental institutions and places elected councillors as the leading advocates for their communities”.<sup>30</sup>

### Conclusion: the benefits of choice and voice

45. The Government, then, believes that wider choice, and especially choice of provider, is vital to give users a central role in public services, while a stronger voice through a range of representative public bodies and complaint and redress mechanisms is needed to complement it. Choice and voice, Ministers believe, can work together to ensure that public services are responsive.

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<sup>28</sup> Both published on 31 January 2005.

<sup>29</sup> Office of the Deputy Prime Minister, *Vibrant Local Leadership*, 31 January 2005, para 62

<sup>30</sup> *Ibid.*, para 31

## 3 Choice: the evidence

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46. In this chapter we examine the arguments which surround choice in public services. We consider in particular the evidence we received about the issues set out below, which seem to us to be the most important in the current debate:

- public attitudes to choice;
- choice and capacity;
- choice and equity;
- choice, markets and the private sector;
- choice and efficiency; and
- choice and the performance of public services.

### Public attitudes to choice

47. The proponents of greater choice in public services argue that there is an unmet demand for choice from the general public. The supposed death of deference, and the increasing sophistication of private sector marketing, are said to be forcing public services to offer a wider and wider range of choices to their “customers”. However, the evidence on this point is mixed.

48. The Government told us that “there is substantial evidence that users of public services in Britain desire increased choice”.<sup>31</sup> However, the Rt Hon Lord Hattersley argued, to the contrary, that schemes to extend choice largely represented an admission of failure to deliver good local services, “If there were a uniformity of adequate provision—a hospital bed as soon as it was needed, a successful school in every neighbourhood—choice would become no more than the exercise of whims and foibles”.<sup>32</sup>

49. Professor Allyson Pollock also believes that choice is not wanted in healthcare:

“unlike a Woolworth’s pick-and-mix sweets counter, healthcare isn’t something we even want to make choices about. What we want, by and large, is to know we will get nothing but the best, and that there are enough well-trained, motivated professionals available near enough to where we live and work to provide it. We want clean, quiet, hospital wards with appropriate privacy and decent food”.<sup>33</sup>

50. Some of the statistical evidence nevertheless suggests that choice is popular. A recent YouGov poll, reported by the Government, found that a majority in the UK believed that more choice would help to improve public services:

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<sup>31</sup> CVP 24, para 3.2.2

<sup>32</sup> Lord Hattersley, “Appeasing the Labour right is futile”, *The Guardian*, 13 September 2004

<sup>33</sup> Allyson Pollock, “Markets will value cash over caring” *The Times Higher Education Supplement*, 27 August 2004

“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”.<sup>34</sup>

51. However, the NAO, having taken evidence about public attitudes to school choice in a series of surveys, considered that parents believed that choice played a subsidiary rather than a central role in education:

“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”.<sup>35</sup>

52. But the real picture is yet more complex. Not only do the popularity and appropriateness of choice vary from service to service, but attitudes to choice differ markedly from social group to social group. The Government acknowledges this divergence, but sees it in positive terms:

“choice is popular across all age and socio-economic groups, including those patients from black minority ethnic backgrounds, those on lower incomes and the unemployed. For example, the Picker Institute evaluation of the London Patient Choice Project found that 80.2% of patients on below average incomes would consider moving to another hospital for treatment compared to 94.3% of those on above average incomes, similarly 78.2% of unemployed respondents compared to 91.2% of employed and 83.1% of white respondents compared to 82.7% of non-white respondents”.<sup>36</sup>

53. On the other hand, the NAO interpreted similar data in a very different way, reporting that:

“Men were considerably more likely than women not to welcome personal choice at referral and to prefer to leave decisions to their GP. 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”.<sup>37</sup>

The relative unwillingness of older people to exercise choice is especially significant, given that they tend to be frequent users of the NHS.

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<sup>34</sup> CVP 24, para 3.2.8

<sup>35</sup> CVP 12, para 17

<sup>36</sup> CVP 24a, para 21

<sup>37</sup> CVP 12, para 85

54. The level of enthusiasm for choice also varies according to the nature of the individual scheme. It is clear from such examples as choice-based lettings that some schemes for greater choice are popular because they allow users to take charge, to exercise greater power and control over their service, and because they are seen as having a number of other virtues. An evaluation of a range of choice-based lettings schemes produced “positive findings”:

“...The ODPM’s review of the pilot programme in England and Dutch studies have come to similar conclusions that customers generally prefer the new system compared to traditional approaches because of its transparency, fairness and ability to exercise greater relative choice. More detailed case studies... support this perspective. For example:

- 80% of respondents to a Harborough Home Search Survey who could compare the new system with the previous system preferred the former; and
- Customer focus groups in the Home Connections scheme in Central London preferred the new approach”.<sup>38</sup>

55. Evaluations of the direct payments scheme for social care have also been generally positive. The National Consumer Council’s Policy Commission on Public Services found that:

“Direct payments allow consumers to make arrangements with individual staff, improve accountability and promote independence. They also encourage consumers to take responsibility for arranging their own services, and provide support for those wishing to organise their own services, and provide support for those wishing to organise their own care”.<sup>39</sup>

56. On this point we were interested to hear the evidence of Peter Hay, Birmingham City Council, who described the benefits of the move to direct payments for people with physical disabilities:

“instead of receiving a service where we send in our own carers to get them out of bed and get them on their way to work, roughly at a point in the morning between seven and nine, by direct payments they take on the employment of their own home carer. They appoint, select and then recruit who they want to do it. I remember very clearly the person I have in mind saying to us, ‘if you are going to wipe my bottom, I am going to choose who you are’. Previously they took who came in through the door at the time”.<sup>40</sup>

57. Nevertheless, there are doubts as to whether the public would pay for choice if it were likely to add significantly to the tax burden. Research carried out by MORI for the Audit Commission asked whether respondents thought that taxpayers should have to pay more in order for service users to have more choice in eight particular services. They found that “In every case, more than half of the respondents thought that taxpayers should not have to

<sup>38</sup> CVP 17

<sup>39</sup> The National Consumer Council’s Policy Commission on Public Services (2004), p 45

<sup>40</sup> Q 387

pay more for users to have more choice”. They went on to comment that “More choice and higher taxes to pay for it just do not go together”.<sup>41</sup>

## Choice and capacity

58. If people are to be offered a wider choice of service provider, there must be enough capacity available to satisfy their demands. The Prime Minister has said that “choice is meaningless unless there is capacity in there, unless you are providing, for example, the good schools”.<sup>42</sup> Without adequate capacity, there is a danger that freedom to choose can simply mean freedom to choose second, third or even fourth choice.

## Secondary education

59. Choice of secondary school is a case in point. Currently, although across England as a whole 85% of parents are offered a place for their child in their preferred school, almost three quarters of parents apply to their nearest school and some parents do not apply to popular schools because they are oversubscribed.<sup>43</sup> In fact, the Department for Education and Skills (DfES) website which advises parents underlines the importance of such realism, stating candidly that “You should not risk wasting your first choice by choosing a school where you stand little chance of getting a place”.<sup>44</sup> As Tim Boyes, the Headteacher of Queensbridge Secondary School in Birmingham told us “when [parents] are making their choices, they have some realism about what is possible, and know that if they make stupid choices they are wasting a valuable strategic choice which is not really a choice”.<sup>45</sup>

60. Problems with capacity are particularly acute in urban areas. In London, there “is often a shortage of school places and this creates additional tensions in managing demand”.<sup>46</sup> In London only 68% of children were offered a place in their parents’ preferred school; likewise in Birmingham only around 65% of students secured a place at their first choice school. The problem, however, is not one of overall shortage, but of imbalance. The Minister of State for Education, Stephen Twigg MP, told us that there were currently 700,000 surplus school places; they are unfortunately not in the “right” places to meet the demand generated by parents.<sup>47</sup>

61. It is argued that, in light of this, schools should be allowed to increase in size in response to demand, and that it should be made easier for new schools to be established. This would, in theory, prevent schools from becoming oversubscribed. Professor Harry Brighouse of Wisconsin University has explained that “it’s important to note the parental-choice models will require the building of spare capacity into the system—so popular schools can expand to meet increased demand as well as government funding for

<sup>41</sup> Audit Commission, *Choice in Public Services*, September 2004

<sup>42</sup> Liaison Committee, Oral Evidence given by the Rt Hon Tony Blair MP, HC (2003–04) 310-ii, Q 17

<sup>43</sup> DfES, *Research Brief No. 278: Parent’s experience of choosing a secondary school*, June 2001. The figures here relate to the admissions round in 2000.

<sup>44</sup> [www.parentscentre.gov.uk](http://www.parentscentre.gov.uk)

<sup>45</sup> Q 327

<sup>46</sup> DfES, *Research Brief No. 278*, June 2001

<sup>47</sup> Q 484

transporting poor children”.<sup>48</sup> In its Five Year Strategy for Children and Learners the Government recognises this current constraint and makes proposals for increasing the number of places available in popular and successful schools.<sup>49</sup>

62. However, Dr Hunter expressed his view that letting popular schools expand to cope with demand for places “cannot be a universal solution because schools are often twice as popular simply because they are not too big. Parents applying for a school with twice as many applicants as places would be horrified if they all got in and the school doubled in size”.<sup>50</sup> The validity of this view was underlined by the results of a survey undertaken by the Times Educational Supplement, which reported that many of the most successful state schools in the country were reluctant to agree to the Government’s wish that they should expand to meet increased demand.<sup>51</sup>

63. Thus secondary school choice is very often a matter of second, third and even fourth choices. Although a world where users of public services get their ‘second choices’, as Professor Brighouse suggested to us, might “not be a terrible thing...if lots of people are making second best choices because they want the security of it, that may not be so terrible”, this reality is often missed in some of the rhetoric of choice, which tends to suggest that the first choice will always be available.<sup>52</sup>

64. Intelligent management can help to increase the effective capacity of the education system. Here, it is not competition but collaboration that is the key to wider choice. On our visit to Birmingham, for instance, we heard evidence of the value of co-operation between schools to meet the growing need of their students for a diversity of courses. We heard from Chris Palmer of the City’s Education Department that:

“it is possible to go a lot further towards establishing choice within schools and through the collaboration of a partnership of schools working together. We are reaching a situation where one individual school or college for that matter cannot, in and of itself, meet the full level of demand that real choice in the education system would demand, which implies that schools, colleges and other providers working together collaboratively ... What we are talking about is creating a system that is led by a demand side rather than by the supply side, because in that way you can begin to develop real choice”.<sup>53</sup>

65. The Government’s Individual Learning Plans have been welcomed by the National Consumer Council’s Independent Policy Commission precisely because they are driven by demand and not supply:

“ILPs [Individual Learning Plans] focus on individual pupils, and clearly state the rights and responsibilities of all parties... The Commission consulted pupils about ILPs. They were positive about them in principle and agreed flexibility in learning

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<sup>48</sup> Harry Brighouse, “Why the left should now learn to love education vouchers”, *The Independent*, 2 April 2002

<sup>49</sup> DfES, Cm 6272, July 2004, p 8

<sup>50</sup> Philip Hunter, “Schools: more options, less choice” from *The Guardian*, 9 March 2004

<sup>51</sup> Times Educational Supplement, 14 January 2005

<sup>52</sup> Q 245

<sup>53</sup> Q 334

linked to personal objectives would improve their educational experience and outcomes”.<sup>54</sup>

### **Health capacity**

66. A more consistently optimistic picture emerges from the experience of the “choice of provider” pilot schemes in health, which are in some ways pragmatic products of the Government’s drive to reduce hospital waiting times by using capacity wherever it appears within the system. According to Professor John Appleby of the King’s Fund, the main objective of the two pilot schemes “was in a sense to bus patients around from longer lists to shorter lists”. He believed that choice was almost an incidental consideration:

“It is couched in terms of patient choice; but in a way you could look at that experiment as an almost military style capacity planning exercise to make sure the beds are here, the patients are over there—‘how do we get these patients into those beds?’ That is what the exercise was really about”.<sup>55</sup>

67. As we noted in paragraph 20 above, these schemes have proved generally popular with patients. They have reduced waiting times, according to a survey reported in the Government memorandum “the choice pilots in elective surgery have dramatically brought down waiting times in the areas in which they operate. Following the introduction of patient choice in London, average waiting times fell by a substantial 19.4% compared to 7.6% in the rest of England”.<sup>56</sup>

68. But the extension of patient choice schemes to cover a much wider range of specialties raises the issue of NHS capacity. The Secretary of State for Health, Rt Hon John Reid MP, has made it clear that he is prepared to countenance the closure of hospitals in cases where the verdict of patients under the new competitive regime of choice is negative.<sup>57</sup> Yet the economics of hospitals are complex. In the coming era of choice, the NHS may well be faced with some difficult decisions, involving the possible loss of whole hospitals because one or two major specialties are performing badly. For example, the difficulties of a cardiac unit which fails to attract enough patients may threaten the existence of a hospital with an otherwise excellent range of clinical resources. This may, naturally, be balanced by the growth of new facilities in hospitals which are successful in the marketplace of choice. Nevertheless, there is no guarantee that such hospitals will be easy and convenient for patients and their families to reach.

69. Just as significant are potential shortages of medical staff. Although the Government has embarked on a concerted and in many ways successful programme of recruitment to the NHS, and there has been a substantial expansion in medical education, the supply of staff is not infinite. The Royal College of Surgeons said in February 2005 that most of the Government’s targets for additional consultant numbers had not been met:

<sup>54</sup> The National Consumer Council’s Independent Policy Commission on Public Services (2004), p 24

<sup>55</sup> Q180

<sup>56</sup> Dawson, Jacobs and Martin, *The London Patient Choice Project: Objectives, Structure and Preliminary Results* (2003). Unpublished paper. Quoted in CVP 24, para 3.4.17

<sup>57</sup> *The Daily Telegraph*, 3 February 2005, p 12

“While there have been a number of short-term policies aimed at increasing capacity within the NHS, the longer-term implications of many service needs and the Government’s changes mean that an additional 2760 posts will be required by 2010. More training opportunities and resources are imperative now”.<sup>58</sup>

70. To provide the extra capacity the system needs in a time of widening choice, both the NHS and the private sector will have to continue to draw heavily on overseas sources, which is not a panacea for such problems. The Royal College of Nursing, for instance, is clear about the limitations of such a policy:

“Evidence suggests that targeted, international nurse recruitment can only be a short-term solution to domestic shortages. The global nursing crisis means that more and more countries with nursing shortages are recruiting from abroad. This is leading to an increasingly competitive labour market and, if current trends continue, it is likely that the countries that traditionally supply nurses will reach a limit”.<sup>59</sup>

### **Housing capacity**

71. In many areas there is undoubtedly a problem with capacity in social housing. Camden Council told us that “14,000 applicants are on Camden’s housing list, of whom about 4,000 actively chase around 1,400 annual vacancies in Camden”.<sup>60</sup> However, even in such an urban area, where demand far outstrips supply, choice has been introduced in the form of CBL. Similarly, CBL is in operation in Newham, where there is also a shortage of social housing.

72. Nevertheless, the ability to give effect to the choices of tenants in areas where there is strong demand for scarce social housing is inevitably constrained. Chris Wood, Director of Housing at Newham, told us that “in one of the popular areas the waiting times [under CBL] can be eight or nine years”, although “for a similar sized property [elsewhere] that same person could wait half the time or less”. Desirable housing in Newham can receive more than 400 bids in one fortnight. As Dr Tim Brown of de Montfort University told us “in high demand areas what is being changed is the process. Choice-based lettings does not affect the supply. If it is a high demand housing market it is still going to be high demand”.<sup>61</sup>

73. Government-sponsored research on CBL pilots found that “some authority officers felt that the word ‘choice’ itself was misleading. While applicants can choose a property they cannot necessarily have it. One project manager considered that it would be more appropriate to say that the applicants can choose to be considered for a property”.<sup>62</sup>

74. There is, on the other hand, some evidence that CBL can lead to efficiencies and savings because it shortens “void times” when properties lie empty between tenants. In Newham,

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<sup>58</sup> Royal College of Surgeons, Press Notice 15 February 2005

<sup>59</sup> Royal College of Nursing, *Internationally recruited nurses: Good practice guidance for health care employers and RCN negotiators* (London, 2004)

<sup>60</sup> CVP 14

<sup>61</sup> Q 116

<sup>62</sup> ODPM, *Research Summary: Piloting choice-based lettings—An evaluation*, 2004

void times under the choice-based scheme are said to have decreased from an average of 50 days to an average of 25.<sup>63</sup> The Minister for Local and Regional Government, Rt Hon Nick Raynsford MP explained to us that the pilot schemes “revealed that there are certain efficiencies that come from a choice-based system, because if you can speed up lettings because there is a greater degree of willingness to move in to a property if you are committed to it—which is the case with a choice-based scheme, as against a traditional allocation scheme—then that in turn will help to tackle the problem of supply”.<sup>64</sup>

## Choice and equity

75. The Government argues that, over the years, public services have failed to remove inequality, and may indeed have made it worse. In their memorandum, Ministers told us that:

“We know that the NHS has not always delivered equitable services. For example, a recent review of the NHS found substantial inequalities in key areas:

- ‘affluent achievers’ had 40% higher CABG [heart operation] and angioplasty rates than the ‘have-nots’, despite far higher mortality from CHD [Coronary Heart Disease] in the deprived group...
- a one point move down a seven point deprivation scale resulted in GPs spending 3.4% less time with the individual concerned”.<sup>65</sup>

76. The Government believes that choice will help to correct these imbalances:

“Patients who are better informed may also have better access to choices about their healthcare. We believe these choices should be accessible to all; by explicitly introducing patient choice and providing the necessary information and support arrangements, these benefits will be made available to all patients. Targeted information and support may be provided ...guiding patients with the greatest need through the system and enabling them to make informed choices”.<sup>66</sup>

77. Ministers’ belief that the extension of choice, properly managed, would be good for equity was challenged by a number of our witnesses. The critics expressed concern that greater choice would merely give the articulate and the prosperous an even better opportunity to take advantage of the best in public services. In particular, those who had access to, and could make best use of, information about the performance of services would enjoy an unfair advantage over others who were less fortunate. We now examine the question of choice and equity in the light of evidence about three issues: choice of secondary school; the availability of information about services; and equity in social housing.

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<sup>63</sup> Qq 155–158

<sup>64</sup> Q 483

<sup>65</sup> CVP 24a, para 19

<sup>66</sup> *Ibid.*, para 20

### **Tackling inequality in ability to choose**

78. We identified two separate but related threads to the argument about inequality and secondary schools. Firstly, there is inequality in parents' ability to choose. Dave Prentis, General Secretary of the public sector union UNISON, decried the Government's argument that choice could help defeat inequity:

“What has emerged is a picture of increasing social polarisation. All too often it is the poorest and most vulnerable who end up in the worst schools, whilst the better off get to go to the most desirable. More affluent families are more likely to be able to buy in the right place to get a place in a good school, or to be able to transport their children to schools outside their immediate area. Oversubscribed schools have tended to prefer those from the most privileged backgrounds. It can't be right that schools can cherry pick the pupils”.<sup>67</sup>

79. The NAO also identified a problem, telling us that the current policy relating to choice of secondary school appeared to produce unfavourable results for certain groups:

“Nationally the impact of a mother being from a black or other minority ethnic community 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”.<sup>68</sup>

80. This matched the experience of Tim Boyes, Headteacher of Queensbridge School in Moseley, Birmingham, which is surrounded by grammar and over-subscribed schools. Mr Boyes told us that:

“...choice itself perpetuates or exacerbates inequality if there are not checks and measures in a system where people do not have equal power in the choosing... Because we are working with an unequal playing-field, because the resources of my school do not match the resources of the grammar schools because of the inequality of inputs and history, if you have unbridled choice you are not only going to perpetuate but exacerbate inequality”.<sup>69</sup>

81. Intelligent refinements to the detailed design of choice schemes can result in improvements in equity. We have noted above (paragraph 15) the reforms that have been introduced with the intention of simplifying the system for choosing secondary school places. Because they remove or reduce the opportunity to manipulate the system, the reforms are seen by some commentators as being fairer to all. The Chairman of the Education and Skills Committee, Barry Sheerman MP, commented that:

“By being fairer, the new system is going to cause greater disappointment to the articulate people who were very clever at playing the old system, because they had the advantage of higher levels of knowledge, information and networks. It makes in much more difficult, if nigh on impossible, to play the system anymore”.<sup>70</sup>

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<sup>67</sup> Speech to The Guardian Public Services Summit, February 2005

<sup>68</sup> CVP 12

<sup>69</sup> Q 336

<sup>70</sup> As quoted in “Education: Fair game”, *The Guardian*, 26 October 2004

82. Charter schools are one way in which US educationalists employ choice to support equity. These are non-sectarian public (state) schools which operate with freedom from many regulations which apply to traditional public schools. In order to be eligible for funding under the Department of Education Charter Schools Programme, these schools must conduct a lottery if more students apply for admission than can be accommodated. Although certain categories of students, such as siblings or children with special educational needs, may be exempted from the lottery the system generally aims to provide students with an equal chance to gain admission to a charter school.

### **Tackling inequality in educational standards and outcomes**

83. The second thread is inequality of school standards and outcome. Here, international experience suggests that, where it is used with care, choice can be a help rather than a hindrance to greater equity. As part of its work on public service reform the Committee visited the United States, where extensive parent choice schemes are in operation. Voucher systems apply in several states, but most of the schemes restrict the offer of vouchers to a specific group of pupils, and they are often aimed at improving the chances of poorer children. For instance, in Milwaukee, Wisconsin, vouchers are supplied only to children of low income families and in Florida vouchers are restricted to all students in schools which are consistently poor performers.

84. We found, during a visit to North Carolina, that charter schools could help to raise standards at both elementary and secondary level, and that students of all abilities could benefit from the environment they created. At Hope Elementary Charter School in Raleigh, for example, in a very low-income area, class sizes averaged around 13—and results were promising. North Carolina teachers told us that these small classes allowed them to concentrate their efforts better on those with special educational needs—another way of making education more equitable. Analysis of the performance of charter schools across the USA bears out this impression. One large study concluded that “The results show that charter schools are especially likely to raise the achievement of students who are poor or Hispanic. This is a useful finding because charter schools serve students who are disproportionately likely to be minorities or poor”.<sup>71</sup>

### **Selection by provider**

85. The principle of user choice is, however, subverted whenever popular schools or hospitals are in a position to choose users, rather than vice versa. As the Government itself acknowledges “It is argued that providers, especially if they are over-subscribed, will have power to select the users to whom they provide services, the easiest, cheapest, those who are most likely to boost their ratings in the league tables”.<sup>72</sup>

86. The danger is most acute in secondary education, as we found when we visited Birmingham. Chris Palmer of Birmingham City Council doubted that, where selection was made by schools, parents were really being offered an authentic choice “What has been created is a system in which there is a variety of schools, what the Government might call

<sup>71</sup> Caroline Hoxby, “School choice and school competition: Evidence from the United States”, *Swedish Economic Policy Review* 10 (2003), p 11

<sup>72</sup> CVP 24, paras 3.5.1–3.5.2

‘diversity’, but having a variety of schools does not equate with parents having a choice. When it comes to which school you go to, choice is an illusion rather than reality”.<sup>73</sup>

### **Unfair geography**

87. Public services are effectively denied to the public (particularly to disadvantaged people) if they are unable to access them because they are hard to reach. If public transport is poor, or local offices are closed, services fail to help those who need them. The point was made by Mark Serwotka, General Secretary of the PCS union:

“If the government are serious about choice then they should look at how you access public services, the channels through which you get advice, make an application or get help. Those channels shouldn't be restricted to call centres and the web, but should be supported by face-to-face interaction. Yet job losses and the resulting office closures on the scale the government are proposing will deny that choice, stripping out services at the heart of many rural and urban communities”.<sup>74</sup>

88. Geographical unfairness is also seen as a weakness of the current system of school choice. The system is said to give prosperous people the opportunity to exercise a wide choice of school because they are able to move to the catchment areas of high performing or popular schools. When popular schools select using the common criteria of distance to school or catchment area, prices of local properties often rise, sometimes quite substantially. Philip Collins, Director of the Social Market Foundation, told the Committee that, where one school at one end of town is good, and another at the other end of town is under-performing, the constraint was not choice, but geography:

“It is the fact that the choice maps on to residential segregation. Although it would be better for everyone if both schools were wonderful—of course it would be—the fact is that they are not, and the people who live in the bad part of town are forced to go to that school because of the geographical constraint”.<sup>75</sup>

89. In rural areas, a different kind of inequity can take hold. There is an argument that choice of provider is largely irrelevant where schools or hospitals are few and far between. The Government responds to this by pointing out that Britain is highly urbanised, with 90% of the population in urban areas. This is particularly the case in England, where:

“32% of maintained mainstream secondary schools ... have two or more schools within one mile of them, 70% within two miles, and 80% within three miles. Since the National Travel Survey shows that the average length of the journey to school for 11–16 year-olds in England is three miles, this implies that four fifths of English schools have at least two other potential choices, attendance at which would entail little if any extra travelling”.<sup>76</sup>

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<sup>73</sup> Q 324

<sup>74</sup> Speech to fringe meeting, Labour Party Spring Conference, 11 February 2005. The PCS also gave us examples of how the closure of Government offices in the West Midlands had appeared to reduce the accessibility of services (CSE 12)

<sup>75</sup> Q 15

<sup>76</sup> CVP 24, para 3.4.10

90. But transport costs can be a serious obstacle to fairness, and practical assistance with such costs can help to alleviate the disadvantage suffered by poorer people who live a long way from good schools, as Mr Collins suggested to us:

“In my view you have to subsidise transport; otherwise the effective choice is completely reduced for people who cannot afford to get from A to B. The bottom 10% by income in this country travel half a mile to school; the top 10% travel three and a half miles to school. That is just because they have got cars and their choices are much greater for that fact”.<sup>77</sup>

### ***Choice and information: a question of equity***

91. For service users to make well-informed choices between providers, they need to have both easy access to, and the ability to interpret, accurate information. Those who are less well-educated or who lack access to reliable sources of information will be put at a disadvantage if the quality and presentation of such information are poor. The internet has vastly increased the amount of information which can be provided to service users, but it is not easily accessible to all. Dr Brown explained the difficulties in relation to information about the availability of accommodation in choice-based lettings:

“Basic information is usually made available through newspapers and/or freesheets. ... Detailed property information including maps and photographs can be provided on websites. However, only between 10–20% of applicants are likely to have access to the internet at home ... there is a real danger that the digital divide might reinforce social exclusion and inequalities in the letting process”.<sup>78</sup>

92. Usable information is therefore not always readily accessible to those who are least educated and most vulnerable. The need is likely to be especially pressing in healthcare, where information is often technical and difficult to interpret by lay people. The King’s Fund told us, for instance, that:

“a crucial piece of information which is not routinely collected in the NHS on a comparable basis is the impact the NHS has on individual patients’ health status. While knowledge of variations in length of stay, or readmission rates will no doubt play a part in many patients’ choices, we would suggest that knowledge of the variations in health outcomes—of individual clinical teams, clinicians, treatments etc—is vitally important”.<sup>79</sup>

93. The implementation of the right of access to information under the Freedom of Information (FOI) Act 2000 in January 2005 has sharply raised the stakes in this debate. FOI will make a significant difference in a number of public services. The prospects are good that FOI will, for instance, give greater power and control to patients by allowing them to have access to a far wider range of information about the performance of hospitals and clinicians, but it will also demand a lot of the NHS if the information, especially death

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<sup>77</sup> Q 42

<sup>78</sup> CVP 17

<sup>79</sup> CVP 19, para 2.5.3

rates of individual surgeons' patients, is not to become in some cases misleading and even dangerous. Advice and intelligent interpretation of the raw information will be vital.

94. To assist secondary school choice, a number of sources of information are already available to parents, including league tables, OFSTED reports and admissions booklets produced by local education authorities. However, the usefulness and relevance of this information was questioned by the NAO. The NAO found that the performance of schools in providing unambiguous, usable information about admissions criteria was variable, and that most parents put the stress on informal sources of information, such as school visits, rather than the school prospectus or other literature. Further inequalities are thereby introduced "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".<sup>80</sup>

95. The ability to interpret information is as important as its availability. There have, for example, been criticisms of the direct payments scheme for social care, because there is evidence that the people who receive the payments require considerable advice and help to make sense of what is on offer from the wide range of providers. The sheer variety of public and private sector services on offer is said to cause difficulties for those who have to make a choice in a fragmented market.<sup>81</sup>

### ***Supporting choice and the role of professionals***

96. From this evidence it is clear that the vulnerable and disadvantaged need effective support and guidance to help them make the most of choice. Without such help, the danger is that choice will become the enemy of equity in public services.

97. Yet there are disturbing signs that many professionals, in the NHS at least, lack the skills necessary to make choice work effectively and fairly for all. The need for proper support and clear information in the field of health, with its complex technical language, is particularly obvious. We were dismayed, therefore, to read the results of recent research which suggests that medical professionals in the UK tend to be unwilling to discuss medical treatment with their patients. In this respect, they appear to lag behind their colleagues in many other countries. The research, which examined patient "engagement" in primary care in five countries—Australia, Canada, New Zealand, the USA and the UK found:

"indications that health care is delivered in a more paternalistic fashion in the NHS. The United Kingdom performed worse than the other countries in relation to information about medicines, shared decision making, patients' access to records, preventive advice, and self management of chronic disease.

"More than a third (37%) of those in the United Kingdom taking regular prescription medicines said their doctor had not reviewed their medication in the past two years and 39% said they had not been given an explanation of likely side effects of their medicines, a notably worse result than the other countries. British

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<sup>80</sup> CVP 12, para 54

<sup>81</sup> The National Consumer Council's Policy Commission on Public Services (2004), p 45

patients also reported the worst results in relation to involvement in decision making: only 27% reported that their doctor always tells them about treatment choices and asks for their ideas and opinions, compared with 41% in New Zealand and 43% in Australia”.<sup>82</sup>

98. In February 2005 a survey published by the Healthcare Commission confirmed the impression that communication was not one of the current strengths of the NHS. Patients were asked to assess their experiences of accident and emergency units and outpatients departments. The figures were generally positive, but patients did complain about the amount and quality of information they received:

“Patient involvement was found to be a key issue for patients visiting both emergency and outpatients departments: 20% of outpatients felt they were not getting the right amount of information for them to be fully involved in their care. Particularly concerning was the finding that only 49% of patients leaving A&E were given any information regarding possible side effects of new medication”.<sup>83</sup>

99. Work in the West Midlands also suggests that, while doctors need to offer their patients more help, the fault may also lie with the failure of the NHS to provide the necessary information:

“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”.<sup>84</sup>

### **Equity and housing**

100. Choice can also enable the user to take charge in the field of housing. Chris Wood, of Newham Council, was enthusiastic about the way CBL gave tenants choices that had previously been the exclusive preserve of home owners:

“[CBL] has transformed the nature of my relationship with the people who are coming to the council asking for housing. It has given them control and greater power than can be exercised in their choice of housing. I strive to ensure the system is similar to that that we enjoy in the private market”.<sup>85</sup>

101. The parallel, of course, is not an exact one. We have noted the lengthy waiting times for some popular properties in Newham; they would not be seen as acceptable by any private house buyer. But Mr Wood pointed out that CBL schemes could be modified to deal with the needs of the most vulnerable:

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<sup>82</sup> Angela Coulter and Deborah Rozansky, “Full Engagement in Health”, *British Medical Journal*, 20 November 2004, p 1197

<sup>83</sup> Healthcare Commission, Press Release, 21 February 2005

<sup>84</sup> CVP 12

<sup>85</sup> Q 111

“All the choice-based lettings schemes that I am aware of hold back some properties for emergency applicants. I think in Newham it is around about 75% of our properties we advertise through the scheme, but if there are life and limb situations then obviously there is an opportunity to move people urgently into properties and that protects the most vulnerable people in the most extreme circumstances”.<sup>86</sup>

102. In housing, there are also other effective ways of helping those who are most vulnerable. The Government applauded the Supporting People Scheme which “provides more choice to residents with the greatest need by pooling together several housing related funding streams into one pot for allocation to vulnerable users. This removes the burden of applying for different benefits and enables a more personalised benefit package to be designed”.<sup>87</sup> In some cases, indeed, choice itself can help to produce better information for users. There was said by Dr Brown to be :

“a growing accumulation of evidence that customers consider CBL [choice-based lettings] to be much easier to understand. A particularly positive feature is that feedback is provided on successful lettings i.e. property location, the number of bids / responses, and the key selection criteria (e.g. priority card / time on housing register etc). This enables households themselves to check on outcomes rather than relying on the ‘word of housing officers’!”.<sup>88</sup>

103. However, Dr Brown also told us that, “The ODPM evaluation of the pilot programme [of CBL] pointed out that one of the major weaknesses of some of the 27 schemes was that the needs of vulnerable groups were not fully addressed at the outset”.<sup>89</sup>

## Markets and private providers

104. Competition between providers, especially schools and hospitals, is at the heart of much Government thinking about choice. As parents and patients make their preferences known through choice, schools and hospitals will, it is claimed, receive an unmistakable signal, positive or negative, about their performance and respond appropriately.

105. However, markets (or quasi-markets) do not always work perfectly. The current extension of patient choice to cover a wider range of specialties, for instance, raises some difficult issues for the NHS. As we noted earlier (paragraph 68) one of the risks posed by such substantial expansions of the principle is that, in time, as choice becomes a more pervasive feature of the NHS, some NHS hospitals may fail to attract enough patients to remain viable, thus narrowing the range of choice for patients.

## Choice and the private sector

106. Capacity, and the ability of the public sector to overcome capacity constraints, are always likely to be limited. It is therefore argued, by Ministers and others, that commercial,

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<sup>86</sup> Q 117

<sup>87</sup> CVP 24, para 3.2.4

<sup>88</sup> CVP 17, para 4.4.2

<sup>89</sup> *Ibid.*, para 4.4.1

not-for-profit or voluntary organisations should be given more opportunities to provide public services.

107. The Business Services Association, which represents major companies providing outsourced services in the UK, Europe and elsewhere, concurs:

“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”.<sup>90</sup>

108. The think-tank Reform offered some evidence of the successful use of private healthcare organisations to provide publicly-funded services in Europe:

“In Germany and Switzerland, for example, citizens are able to choose between competing social insurers. Patients have a choice of providers and waiting lists are virtually unheard of since competing providers usually treat all patients. In Germany, half of all hospitals are non-state-owned and in Switzerland, one third are”.<sup>91</sup>

### ***Choice: a step to privatisation?***

109. However, a number of witnesses raised serious objections to the introduction of private and voluntary providers. For them, patient or parent choice was seen as a Trojan horse for the marketisation, followed often by the privatisation, of public services. These concerns were particularly prevalent in the case of healthcare. Professor Pollock told us that the promise of greater choice in NHS care was driven by a policy based on commercial principles that were both alien and inappropriate. In particular, the private sector was being given guarantees of the amount of work that it would win:

“Choice implies substitution. Government policy is that health services can be substituted for each other like manufactured goods. In health care this is problematic because there is often no substitute for the appropriate intervention or treatment and patients do not seek to trade off the cost of care against its quality. However, in its latest health service reforms the Government is using choice in the restricted sense of a choice of provider where the variable is price not quality.

“Thus the Government has stated its intention to move 15% of elective work out of the NHS into the independent sector and is encouraging the creation of joint ventures with foundation trusts in order to bring in transnational health care corporations. It is moving towards a market where there is a choice of different providers which compete largely on the basis of price”.<sup>92</sup>

110. In housing, there is some evidence that the use of choice-based schemes is encouraging the wider use of the private sector. Dr Brown told us that the limitations of

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<sup>90</sup> CVP 13

<sup>91</sup> CVP 16

<sup>92</sup> CVP 20

public sector supply were stimulating councils to move on from choice-based lettings, using council accommodation, to a broader range of providers:

“What a number of local authorities have done is to broaden out from choice-based lettings to what I would call a housing options package by making information available about other ways of meeting housing needs, meeting their housing aspirations, promoting shared ownership, low cost owner occupation, the private rented sector and disabled facilities grants as a way of thinking about whether people really do need to move”.<sup>93</sup>

### **Private sector cream-skimming?**

111. We have already discussed the danger that public sector providers will reverse the proper order, choosing users rather than offering choice to users. As we have seen, the temptation is for schools to take on the most amenable pupils and for hospitals to admit the healthiest patients. But such “cream-skimming” is a particularly serious risk where the private sector is a substantial provider of services.

112. Commercial pressures can, for instance, affect equity in education, potentially restricting the choice available to those on low incomes. Dr Hunter told us that he would have no objection to private schools taking part in a state-funded voucher scheme, on condition that they would “accept their share of difficult to teach and local children and if they would accept the same degree of monitoring and inspection as state schools”.<sup>94</sup> He was highly dubious that they would do so, however, telling us “Experience from the assisted places scheme suggests that private schools will only take part in state funded schemes where they are allowed to select the children they receive”.<sup>95</sup>

113. The problem is more serious in healthcare. The British Medical Association feared that a two-tier system would result from the widening of provider choice. It told us that the private sector would in future have “an in-built incentive to select patients that are fit with little co-morbidity, leaving the existing NHS acute sector to cope with more complex cases”.<sup>96</sup> Part of the problem was that the tariff of prices in the PbR scheme was likely to be too insensitive to the mix of cases presented “a coronary artery by-pass graft procedure carries the same tariff whether one or four vessels are stenosed and whether it is a first time or repeated case. Unless the payment regime is made more sophisticated, case selection will be a key factor in the profitability of the organisations concerned”.<sup>97</sup>

114. There is also some suggestion that the present scheme for provider choice in the NHS, with its requirement that patients should be offered the option of choosing a private sector hospital, is threatening to undermine clinical priorities.<sup>98</sup> It is alleged that GPs in the

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<sup>93</sup> Q 116

<sup>94</sup> CVP 21

<sup>95</sup> *Ibid.*

<sup>96</sup> CVP 18, para 34

<sup>97</sup> *Ibid.*

<sup>98</sup> “To support capacity and choice, by 2008, independent sector providers will provide up to 15% of procedures on behalf of the NHS.” DoH, *The NHS Improvement Plan: Putting people at the heart of public services*, Cm 6268, June 2004, para 17

Nottingham area are being encouraged, and sometimes financially rewarded, to send patients to new private treatment centres for routine operations, even though the centres may not have appropriate medical support available in case of complications.<sup>99</sup> If these allegations reveal a widespread problem, they represent the very opposite of wider choice for the patient.

115. The Government acknowledges that what it calls “cream-skimming” by selection is “likely to be a significant problem for choice” across the public services. Its memorandum examines a variety of possible solutions, including “stop-loss insurance”, which allocates extra money to service providers who accept “difficult” and expensive students or patients. Another approach is to restrict the amount of freedom providers have over the choice of users they accept. The Government comes to no conclusion about which of these suggestions is best, saying “The policy challenge is to identify which of these options is likely to be most effective and most consistent with other government policies”.<sup>100</sup>

### **Market costs and market risks**

116. A further possible problem arises where private sector organisations are among those providing public services: the commercial risk premium. Evidence from the Business Services Association demonstrated that the private sector is wary of the heightened risk and inherent uncertainty of providing public services in an era of wider choice:

“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”.<sup>101</sup>

117. The requirement for the NHS to commission at least a minimum proportion of its elective surgery from the private sector is one clear example of the arrangements that are needed to enable the commercial risk to be managed. However, this private sector guarantee can hamper the efficient use of public resources. In areas where the NHS is already performing well using its own facilities, the rule could mean that surgery is carried out in private hospitals which could be performed just as well if not better in NHS hospitals. When we visited Birmingham we heard from the Chief Executive of South Birmingham Primary Care Trust, Graham Urwin, about such a situation:

“In South Birmingham we are already achieving far better than the NHS current standards for access to services, so nationally people are expected to have their planned operations within nine months but if you live in South Birmingham you get them within six months. Nationally, people would expect to see a specialist for an

<sup>99</sup> Observer, 30 January 2005, p 2

<sup>100</sup> CVP 24, para 3.5.15

<sup>101</sup> CVP 13

out-patient consultation within 17 weeks but in Birmingham you get that within 13 weeks. We have not introduced in the past private sector capacity to enable us to deliver Government targets, so we now feel, because this is Department of Health policy, that we have a challenge in catching up. There is not sufficient growth money in the system for us to purchase this private sector capacity from new monies that come into the system, so we will have no choice but to look at opportunities for substitution, to look at work that is currently carried out within the NHS being placed within the private sector”.<sup>102</sup>

## Choice and efficiency

118. Questions about the coherence of Government policies on choice and efficiency emerged when the Committee took evidence from Sir Peter Gershon, who conducted a major efficiency review for the Government which reported in July 2004. Sir Peter told us that there was a trade-off between the scope for choice and the scope for efficiency savings. He recounted his personal experience of the tax system to make the point:

“...unfortunately in January I discovered I owed the Inland Revenue some money under self-assessment. If you look at the form you get it does not actively encourage you to use particular channels; it is completely neutral about which channel of payment you use: cheque, ring up a contact centre, use the banking system, whatever. The costs of those channels are not identical. There are armies of people in the Revenue Department who do nothing but receive envelopes, open envelopes, take cheques out of them and bank them. It is not the most efficient way of dealing with it... That is an area I would reduce choice personally. That would make the new Revenue Department more efficient”.<sup>103</sup>

119. He went on to explain why, in his view, choice might have to take second place to efficiency:

“Why should you have a greater degree in choice in settling with the Revenue than you do if you book a flight with EasyJet where you only have one mechanism of booking a flight?”<sup>104</sup>

120. The diversity of provider which is encouraged by the Government’s policies on choice may also damage efficiency by limiting the ability to introduce economies of scale, one of the central tenets of Sir Peter’s efficiency review. Professor Colin Talbot explained to the Treasury Committee that:

“...one of the aspects of choice ... is that you need to create as many autonomous bodies in the sense of foundation hospitals, foundation schools and so on to be able to compete with one another, which means granting them a degree of autonomy to manage their own affairs. That in itself then raises issues about how do you realise

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<sup>102</sup> Q 323

<sup>103</sup> HC (2004–05) 307-i, Q 62

<sup>104</sup> *Ibid.*, Q 65

some of the economies of scale that are talked about in Gershon in terms of convincing autonomous bodies to adopt central initiatives on purchasing...”<sup>105</sup>

121. In its memorandum the Government took a different line from Sir Peter, denying that there was any necessary contradiction between choice and efficiency:

“Some argue that there are negative implications for efficiency arising from the claim that choice requires there to be excess capacity in the system. This may be true under some circumstances but the margin of extra capacity needed to permit contestability is likely to be small ... Overall ... if there are efficiency losses that arise from these causes, they may have to be accepted in order to reap the gains in efficiency and other areas that arise from the positive incentive effects of choice on user and provider behaviour”.<sup>106</sup>

### ***Inefficient systems: choice’s teething troubles?***

122. The issue of choice and efficiency is also relevant to the current controversies over the financial systems which are being introduced to allow NHS patients to have choices in elective surgery. Crucial to this is the Payment by Results (PbR) scheme which is now beginning to operate in the NHS. The King’s Fund warned us that it was possible for the scheme to be manipulated:

“Evidence from a number of countries suggests that, at the margin, there is a risk ... of gaming on the part of hospitals to assign patients to higher price [treatments]. There will be a need for inspection—involving the individual review of samples of patients’ case notes—to monitor this”.<sup>107</sup>

123. The NHS Alliance, which represents Primary Care Trusts, said that the financial information underpinning the present system of PbR was not sufficiently robust and reliable:

“current finance procedures do not adequately safeguard against errors. The Payments by Results system allows payments to be made regardless of whether the patient’s GP has received clinical discharge information. Family doctors who directly commission services for their own patients could find they have no way of checking costs, nor of correcting any errors”.<sup>108</sup>

124. The Chair of the NHS Alliance, Dr Michael Dixon, was quoted as saying of PbR: “At the moment we just don’t think the system is fit for purpose, partly because the treatment categories are too broad and partly because foundations [hospital trusts] are putting in bills and they are going through on the nod”.<sup>109</sup> There were also reports that hospitals were

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<sup>105</sup> HC (2003–4) 906-ii, Q 56

<sup>106</sup> CVP 24, para 3.4.16

<sup>107</sup> CVP 19, para 2.4.3

<sup>108</sup> NHS Alliance, Press Release, 3 February 2005

<sup>109</sup> *Public Finance*, 4–10 February 2005, p 10

manipulating their results, exaggerating their figures for (lucrative) short-term admissions.<sup>110</sup>

125. The shortcomings of the current PbR system appear to have been recognised by the Department of Health, which in January 2005 significantly amended the plans for the scheme. For most hospitals in 2005/06 PbR will only apply to elective care, with its application to non-elective care, outpatients and accident and emergency deferred for a year.<sup>111</sup> The Health Minister, Mr Hutton, said “Payment by results remains central to implementing patient choice ... We have listened to what the NHS has been telling us, and this will reduce the financial volatility in the system”.<sup>112</sup> These problems may well be teething troubles rather than anything more fundamental, but they need to be corrected very quickly.

### Choice and performance

126. One of the key aims of Government policy is to improve the performance of public services. In the last decade, performance management by means of centrally-set targets, league tables and star ratings has been increasingly used to measure and encourage improvements in performance. Yet, as we found during our inquiry into these questions in 2002 and 2003, targets set by Whitehall can also present their own difficulties.<sup>113</sup> The Government now sees the value of combining a more sophisticated use of central and local targets with a different approach which uses choice to inspire improvements based on markets, diversity and competition.

127. One of the arguments for markets is that they encourage greater effectiveness by putting pressure on producers to improve their performance. Service providers will need to innovate and provide better services or lose users and money and eventually face closure. The Government states in its memorandum that:

“An important part of the reason for extending user choice concerns the incentives it gives for changes in provider behaviour. Looking at the case of choice of provider, those providers who are not chosen have a strong incentive to raise their game. They will have to improve the quality of their service (at least in the eyes of the users), to increase their responsiveness to the users’ expressed needs and wants, and to use their resources more efficiently so as better to attain these ends”.<sup>114</sup>

128. Lord Hattersley was, however, not convinced that public service choice would work in that way:

“allegedly ‘bad’ hospitals and schools would continue to operate, inefficiently, until the Government—not the consumer—decided to close and replace them. The whole

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<sup>110</sup> *Financial Times*, 11 January 2005, p 1

<sup>111</sup> Letter from Richard Douglas, NHS Director of Finance and Investment, to Strategic Health Authority Chief Executives, 10 January 2005

<sup>112</sup> *Financial Times*, 11 January 2005, p 1

<sup>113</sup> HC (2002–03) 62-1

<sup>114</sup> CVP 24, para 3.3.1

process would take so long and be accompanied by such adverse publicity that it could not possibly be used as a general method of improving performance”.<sup>115</sup>

129. Assessing evidence about the ability of extending choice of school to raise standards is complex, but there are signs that improvement is possible. Research by Professor Caroline Hoxby of Harvard University on the impact of charter schools in the United States was cited by the Government in its memorandum. The Government told us that the research “found evidence of strongly improved performance by the public [state] schools, from which she concluded that the efficiency-inducing effects of competition were more than enough to offset any potential effects of cream-skimming”.<sup>116</sup> There is also some limited evidence that the expansion of charter schools in the USA has encouraged traditional schools to achieve better results. Research conducted by the National Bureau for Economic Research in California found that, overall, the results implied an approximate one per cent increase in achievement when a traditional school faces competition from a nearby charter school.<sup>117</sup>

130. There is also said by the Government to be evidence from studies of school performance that “choice and competition in the UK has a positive effect on both quality—as measured by exam and test results—and efficiency”, and “there is evidence from Sweden that standards in the education system have improved faster in government-run schools that face a lot of competition from state-funded but independent schools than in those that do not”.<sup>118</sup>

131. However, Professor Brighouse sounded a warning against drawing simplistic conclusions for the UK from the experience of choice in other countries. He told us that “...the evidence about choice in the United States is mixed and it is also very hard to learn from”. He went on to explain that the design of the schemes was crucial to their chances of success:

“Choice and vouchers are talked about a lot of time by proponents as if they are some sort of magic bullet. You get it all in place and you are going to get these fantastic improvements in test scores, et cetera. My reading of the actual evidence of the way things have worked out in a whole variety of schemes is that it has not worked like that. There have been various kinds of benefits from various kinds of schemes and no benefits from some others”.<sup>119</sup>

132. In health care, there is evidence of improved performance associated with the limited patient choice pilots. We also heard evidence from Reform and others of the potential of radical schemes to increase choice.<sup>120</sup> However, the ability of the market to improve outcomes for patients over the long term has been questioned. The British Medical Association told us that:

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<sup>115</sup> CVP 15

<sup>116</sup> CVP 24, para 3.4.20

<sup>117</sup> George Holmes et al, *Does School Choice Increase School Quality?*, National Bureau of Economic Research Working Paper 9683, May 2003

<sup>118</sup> CVP 24, paras 3.4.18-3.4.19

<sup>119</sup> Q 203

<sup>120</sup> CVP 16

“Choice is also predicated on the introduction of a market in healthcare. Given the lack of evidence that competition increases quality, the BMA is not convinced that the market road is the best route to make the health service more responsive. In any market there will be winners and losers and the BMA is deeply concerned that the NHS is being set up to lose, about the very real threat of destabilising NHS institutions and the closure of much needed services”.<sup>121</sup>

### School diversity, choice, and standards

133. A central plank of the Government’s policy on educational choice is a significant expansion in the number of specialist schools. The Rt Hon Charles Clarke MP, whilst Secretary of State for Education, stated that “Specialist schools lie at the heart of our drive to raise standards and offer more choice in secondary schools”.<sup>122</sup> The Prime Minister claims that diversity in provision is promoting higher standards “One of the things that is really interesting is to read the recent studies that have been done on how specialist schools, and remember half of the schools in the country are now specialist schools, they have been out-performing traditional comprehensives in a big way, and I think that is important. Now there are some very good traditional comprehensives, don’t misunderstand me, but the fact is that the specialist school system is actually leveraging up higher standards”.<sup>123</sup> Yet the evidence is by no means conclusive.

134. The Education and Skills Committee has, for instance, criticised the Government for relying on too narrow a range of evidence to prove that specialist schools produced better results.<sup>124</sup> Professor Ron Glatter told us that research has indicated that “specialist schools produced only a slight performance advantage over non-specialists and this advantage was attributable entirely to two of the four existing forms of specialist, technology and languages”.<sup>125</sup> However, a February 2005 OFSTED Report concluded that “compared with other schools, specialist schools do well against a range of indicators. Leadership and management have improved. Standards are higher and improving at a faster rate”. Yet again, the OFSTED Report was not unequivocal, noting that “the rate of improvement in pupils’ performance in specialist subjects is levelling off ... Less than half the schools met their targets for these subjects”.<sup>126</sup> It is, therefore, not clear that diversity in schools by itself necessarily improves performance.

### Whitehall and local government

135. We have seen that there is concern among some professional groups about the implications of the Government’s plans for greater choice in public service. The same seems to be the case for some in local government. A number of local authorities, for instance, take exception to the suggestion that they are incapable of offering choice to their

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<sup>121</sup> CVP 18

<sup>122</sup> DfES, ‘Clarke gives green light for all schools to become specialist’, Press Notice 2002/0228, as quoted in CVP 02

<sup>123</sup> Prime Minister’s Press Conference, 15 June 2004

<sup>124</sup> Education and Skills Committee, Fourth Report of Session 2002–03, *Secondary Education: Diversity of Provision*, HC 94-I, para 104

<sup>125</sup> CVP 02

<sup>126</sup> OFSTED, *Specialist Schools: A second evaluation*, February 2005

citizens, and that central government has to force them to provide a range of services that are responsive to the needs of users. Camden Council argued that much good work was already being done at local level:

“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”.<sup>127</sup>

136. The value of local authority schemes to enhance choice for users was stressed by the Local Government Information Unit, which suggested that such initiatives could be stifled if Whitehall rigorously imposed its own version of choice. They state that:

“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”.<sup>128</sup>

137. Provider choice of certain kinds, when imposed inappropriately from Whitehall, can also cause financial instability for local authorities. There have, for instance, been a number of cases where tenant ballots on the management of housing stock have left local authorities with the only viable option for reaching the Decent Homes standards being rejected. In April 2002, Birmingham tenants overwhelmingly rejected the option of transferring the housing stock to registered social landlords. This has left Birmingham with a £1bn shortfall. In January 2004 Camden tenants rejected the transfer of the housing stock to an ALMO. In a further ballot, tenants on one estate rejected the second option of a PFI scheme. Camden Council consequently faces a £283m budget deficit in order to meet the Decent Homes target. As Lord Hattersley commented “The right to choose is only maintained as long as council tenants choose what the Government wants—an unlikely prospect”.<sup>129</sup>

138. In the next chapter, we set out some of our main conclusions on the questions which have been raised in this chapter.

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<sup>127</sup> CVP 14

<sup>128</sup> CVP 06

<sup>129</sup> Lord Hattersley, “Give council tenants a real choice”, *The Guardian*, 5 July 2004

## 4 Our conclusions on choice

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139. It is clear from the evidence discussed in the previous chapter that the main questions about the use of choice in public services are highly contested. We now turn to our own conclusions on choice.

### Does the public want choice?

140. The evidence suggests to us that, while public attitudes towards choice are generally positive, few people are likely to name it as their first priority for public services. There are also clear differences when it comes to the various categories of choice, with the identity of a provider often seen as less important than choices from variety, such as options for treatment or access to a wide range of courses. We believe the evidence largely supports the view of Mr James Johnson, the Chairman of the British Medical Association:

“From a political point of view there are two completely different elements of the choice agenda. The one that is always trotted out in a quick sound-bite is the choice of five hospitals to go to if you need an operation. Certainly, our evidence—and we have a patients group in the BMA—is that patients are very, very keen on choice, but they are not keen on that particular bit of it; they think that is irrelevant”.<sup>130</sup>

141. The importance to service users of ‘choices from variety’ was illustrated very vividly by an example given to us by Doreen Harrison, Director of Nursing at the South Birmingham Primary Care Trust, who described the options offered to older people in one of the city’s hospitals. What appears to be trivial can be very important to dignity and quality of life:

“they make choices about times of meals and the kind of meals they want to eat, the times they want to go to bed and get up. As a result of that, we have introduced a protected mealtimes policy so that doctors and other people cannot go in and say ‘we want to examine you now’ in the middle of their dinner. That may seem quite trivial, but that is about exercising choice in your daily life”.<sup>131</sup>

**142. The evidence suggests that, while choice is regarded by the public as an important feature of good public services, it is not necessarily their highest priority. Such schemes as direct payments for social care and choice-based lettings demonstrate that users often value the opportunity to take charge of certain decisions about services and to exercise greater power, control and choice in their lives. Some of the most frequent users of public services appear to place greater emphasis on practical choices which have a direct and immediate impact on their quality of life than on the choice of service provider.**

143. Choice should therefore not be oversold. In some cases, the success of schemes that have been modestly effective in reducing waiting lists or in making the best use of limited school capacity, offering very good second or third choices, has been described in exaggerated terms. This has led to disappointment and disillusionment. The language of

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<sup>130</sup> Q 167

<sup>131</sup> Q 375

some politicians has implied variously and misleadingly that choice is either the solution to all the problems which affect public services or the malign force that will do most to undermine them. The debate must become less theoretical and more practical. The fact is that, as we have discovered by talking to those who use and provide services, choice is only one way, among many, of making public services more responsive.

**144. We believe that some of the problems with choice would be eased if there was more acknowledgement of its limitations. Rhetoric does not match the reality. Too often the ‘choice’ label is applied to schemes in which the most the consumer can hope for is second, third or even fourth choice. It should always be made clear to people what they can realistically expect from the choices they are offered.**

### **Is there enough capacity to make choice work effectively?**

145. Capacity shortages inevitably pose problems for public services. We have seen (paragraphs 61–62 above) for instance that the responsiveness of secondary education to demand is limited; it takes time to build a school, and to add capacity to existing schools. Even if schools could easily expand in response to demand from students, we agree with Dr Hunter (paragraph 62) that quality might suffer. We were impressed by the opportunities opened up by partnerships between schools—offering a wider range of choices than could be provided by one school alone. The value of striking an intelligent balance between competition and collaboration is clear.

**146. Secondary schools find it difficult to respond flexibly to the demand generated by parental choice. It is unrealistic to expect schools to expand and contract in the way that is sometimes suggested. Nevertheless, educational choice, especially choice of subject, can be enhanced by imaginative collaborations and partnerships between schools which make the most rational use of resources.**

147. The limited NHS experiments in patient choice of provider have proved to be a pragmatic way of adding to the capacity of the service and reducing waiting times. They help to make best use of resources, by ensuring that shortages of beds and medical staff in one geographical area are eased or eliminated by the sensible use of under-employed beds and medical staff in another. However, we are concerned that the current nationwide extension of patient choice could stretch the capacity of the NHS, especially if ministerial statements about hospital closures are borne out in practice.

**148. We believe that the evidence shows that specific, limited and targeted schemes for provider choice, such as the London Patient Choice Project and the Coronary Heart Disease Choice scheme make effective use of NHS capacity. They demonstrate that well-designed schemes can help the NHS put choice of provider to good use for the benefit of patients. However, recent ministerial comments about the potential for hospital closures in the era of patient choice raise serious concerns about the future of local service provision, and indeed about the future overall capacity of the NHS. Private hospitals have few additional resources to offer, as most of their major operations are carried out by surgeons who also work in the NHS.**

149. Although the choice available in choice-based lettings is very limited, with waiting times for the most popular accommodation still lengthy, we were impressed by some of its achievements.

**150. The introduction of choice-based lettings has eased the process by which tenants are matched with suitable accommodation, and has enabled tenants to take more control. However, there are limits to the amount of popular housing available, and tenants' first choices often cannot be met. The limitations as well as the benefits of such schemes need to be recognised.**

## Choice and equity

151. We see the quality and accessibility of information, especially on healthcare matters, as central to the debate on choice and equity. The failure in some cases of the NHS and its staff to provide the necessary support makes it more difficult for patients to make informed decisions.

152. However, there are some encouraging signs that the NHS has the ability to adapt to the need to provide professional services in ways that are appropriate to the availability of wider choices. The Patient Care Advisers who supported the patients who were offered choices in the experiment with Coronary Heart Disease treatment were well received and effective. They “played a key role in ensuring that patients had a positive experience of the scheme. They were an important point of contact and support and their role in smoothing patients' path through surgery was greatly appreciated”.<sup>132</sup>

153. The experience of some policies in the United States, including vouchers and charter schools, demonstrates that educational outcomes for disadvantaged people can be improved by well-designed schemes based on extending choice. But the evidence also suggests that such benefits can be undermined where, for instance, schools are able to select their students. Those choice proposals which enable some people to access private provision (for example, to healthcare) if they pay a percentage of the cost clearly have adverse implications for equity.

**154. We have concluded that choice can be consistent with equity, but only if schemes are well-designed and motivated by a desire to reduce unfairness. We believe that certain types of selection by provider in a public service can be incompatible both with equity and with the principle of choice for the user. The Government should, in particular, consider the effects on its wider objectives of selection by schools.**

## Choice, markets and private provision

155. There appears to us to be a real danger that private sector providers will only be willing to deal with the most straightforward (and therefore most profitable) cases. We were unimpressed by the quality of plans to prevent “cream-skimming” in public services generally, and continue to be concerned that the guarantees given to private providers may waste public money and public resources.

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<sup>132</sup> Picker Institute Europe, *Patient's Experience of CHD Choice* (Oxford, 2003)

156. One of the Government's arguments in favour of choice of provider is that it encourages high standards through competition. However, that is far from universally true. Competitive tendering for hospital cleaning seems to have resulted in a significant deterioration in standards, with disturbing personal consequences for some patients and considerable diversion of NHS resources to care for them.

**157. We believe that costs as well as benefits result from the creation of markets and especially the use of private provision in systems to enhance choice in public services. The NHS, for example, is still coming to grips with the implications of the guaranteed level of private sector provision in the current patient choice scheme, and it is likely that it will, to an extent, prove to be wasteful of NHS resources. This effective transfer of commercial risk to the NHS will need very careful monitoring. If necessary, the design of the patient choice system will need to be changed, perhaps with less emphasis on guarantees for private providers.**

158. The Government's plans to prevent the practice of "cream-skimming" by private providers of public services appear to us to be sketchy and inadequate. Ministers need to make an urgent effort to ensure that private providers do not exploit choice schemes to the detriment of the public interest.

159. The Government should also consider the broader public administration implications in cases where direct public provision of services is brought to an end. In particular, Ministers should consider: the effects of the loss of in-house expertise and infrastructure, which can make it difficult to monitor contracts; the earmarking of funds for private contracts for several years ahead, which can bind successors and restrict their ability to set suitable priorities in the public interest; and a loss of knowledge and learning that comes from the removal of direct contact with users.

### Is choice consistent with efficiency?

160. Our session with Sir Peter Gershon revealed the possible tensions between two important principles: choice, with its need to rely on the existence of spare capacity; and efficiency, with its attack on waste. The continuing doubts about the effectiveness of the financial and IT systems intended to support NHS patient choice are also cause for concern.

**161. We consider that there is the potential for conflict between two central goals of Government policy: the drive to produce efficiency savings and the desire to expand choice for the users of public services. It is also disturbing that there are continuing doubts about the effectiveness and efficiency of the financial and computer systems on which the NHS is basing patient choice.**

### Does choice improve the overall performance of public services?

162. The evidence on the effects of choice on the performance of public services is sparse. Even in the USA, where there are studies of the effects of charter schools and voucher systems, there is no consensus. The somewhat limited pilot projects on patient choice are useful, but tell us little about the overall effect of the much larger national scheme now being implemented.

163. We consider that the evidence about the effect on the overall performance of public services of the introduction of greater choice is still scarce and inconclusive. The pilot schemes in health which have been evaluated give some grounds for optimism, but their results will not necessarily read across to the much larger national schemes which are now being introduced. The evidence from the USA and elsewhere on education choice suggests that some schemes are effective while others are not. Choice on its own does not deliver better performance, although it may help.

### The need for effective design and implementation

164. The evidence assessed in this and the previous chapter suggests strongly that the success or otherwise of schemes to provide choice depends particularly on whether the scheme is effectively designed. Professor Brighouse's warnings (paragraph 131 above) about the variations in performance between different school choice schemes across the USA are salutary. Good choice schemes can indeed enhance both equity and efficiency; bad ones, introduced without a full understanding of their environment, may damage the public interest. Local government must be engaged in the process.

165. Local government can do much on its own initiative to offer more choice to the users of public services. Although some councils may be resisting reform, much innovative work is being done at local level. However, local authorities do not always believe that they receive the appropriate credit and support from central government. The Government must ensure that local government is fully engaged in all relevant aspects of the design of schemes to increase choice.

166. We conclude that the Government needs to look more carefully at the detailed design and implementation of schemes for user choice. Evidence from the front line of public services suggests that greater provider choice in NHS healthcare is being introduced with insufficient attention to the need to win the acceptance of either users or staff. We hope that the reforms being carried out to the system by which parents choose secondary schools will be effective in reducing the inequities and distortions which have arisen in the system.

167. It is sometimes not clear whether choice (of provider) is being promoted in order to give more control to the service user or because choice mechanisms are needed to promote contestability and introduce a quasi-market. This can be a source of confusion, both to those providing services and to those using them. There is also the problem of getting the right relationship between 'exit' and voice. The possibility of exit may be required to improve performance, but it should not function in such a way that it undermines the possibility of the operation of the 'voice' route to service improvement.<sup>133</sup> This is a critical relationship, and demands a close attention to the design features involved if choice and voice are to be genuinely complementary.

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<sup>133</sup> Albert Hirschman, *Exit, Voice and Loyalty*, (Cambridge Mass, 1970)

## 5 Making users' voices heard?

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168. The prospect of more choice, which may bring with it the complex and serious policy implications we considered in the previous chapter, increases the need for users to have an effective say in public services. In this chapter we examine central government initiatives and policy on voice, as well as local schemes which have produced positive results for local services and communities.

### Individual choice and collective goods

169. It is clear that individual choices can sometimes conflict with wider public priorities, and that choices can conflict with each other (for example, to pay low taxes and to have quality services). There are policy areas (transport is an obvious example) where the public interest is clearly not to be found simply in the aggregation of individual choices. Present choices can conflict with future choices (as with environmental policy) and the interests of current users can conflict with the interests of non-users and future users. In these cases there is a need for wide-ranging and well-informed debate about the way forward. As Camden London Borough Council told us “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”.<sup>134</sup> On the other hand, the Government is emphatic about the value of choice in strengthening the hand of those for whom ‘voice’ is not effective. There is an obvious need for a coherent collective voice for users and citizens. Adjudicating on such issues must be a matter for collective deliberation rather than individual choices.

170. Individual choice or the cultural norms of a particular group may conflict with decisions reached collectively, in ways that may need to be resolved, in the end, by the courts. The issues are illustrated by the recent case of the Muslim schoolgirl who won the right to wear clothes which were not in line with her school’s overall policy on uniform. Similarly, a choice to have faith-based education may conflict with a choice to have an integrated school system.

171. We found during our visit to Birmingham that many people also have long-standing attachments to their locality and its institutions, and that simple references to the importance of listening to the choices of individual ‘service users’ fail to capture the strength of feeling about community position. Asked why Birmingham’s Council tenants had voted in large numbers against a transfer of their homes to an outside provider (despite the prospect of substantial repairs if provision transferred to an outside body), Carolyn Palmer-Fagan, District Housing Manager, Hodge Hill, Birmingham City Council, told us that:

“For a lot of people... it is about security and safety... Many of them have been tenants for a long time. People who have the ability to go out there and buy their homes or rent privately and so forth do, but what we have in the main remaining are the tenants that need that safety net and the security or umbrella ... It is not only

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<sup>134</sup> CVP 14

about bricks and mortar for them; it is about the other added issues and added value that goes with being a council tenant”.<sup>135</sup>

172. Loyalty to local institutions often appears to play a part when people express doubts about choice in healthcare. The NAO reported that a number of people considered that if they used a hospital in a distant town (perhaps prompted to do so by poor standards or long waits at their local hospital) their local health facilities would decline further. This motivated them to choose their local hospital, whatever its shortcomings.<sup>136</sup>

173. Thus a complex mixture of interests and motivations is at play in the debate about public services. While there are millions of individual needs and preferences, expressed in choices of various kinds, collective interests—local and national—also need to be taken into account. We discuss below the mechanisms that are needed to bring the diverse threads of choice and voice together.

### Constraints on the effectiveness of collective voice

174. We are aware that, just as there can be constraints on the effectiveness as choice as a mechanism for responsive public services and for giving more power and control to communities, there are also constraints on voice, which policy design will have to overcome. The National Consumer Council listed a number of problems with voice, including the fact that the extension of voice was dictated and managed by providers. It might therefore, according to the NCC, fail to offer the same degree of power and control that is produced by greater user choice. Other potential shortcomings of voice included:

- “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 a 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”.<sup>137</sup>

175. These points demonstrate the difficulty of establishing credible and robust mechanisms for making the voice of the user heard through representative bodies. There is also some evidence that the Government is beginning to doubt the value of certain of its

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<sup>135</sup> Q 293

<sup>136</sup> CVP 12, para 86.2

<sup>137</sup> CVP 04

own policies on voice in public services, after initial enthusiasm about the prospect of greater public involvement through representative bodies. Two cases illustrate the point.

## Muted voice: two case studies

### *Foundation hospital boards*

176. There is one recent innovation intended to strengthen the representative voice of the community where progress can be examined in some detail: the establishment in 2004 of the governing bodies of foundation hospital trusts, the product of Mr Milburn's work as Secretary of State for Health. These are directly elected by local people, including patients and staff, and work with the boards of directors to help set the overall direction of the organisation.

177. The evidence on which to assess the potential of foundation trusts to improve services and engage the public is still very limited. It remains to be seen whether such bodies, only a tiny minority of Britain's hospital boards, will in the long term achieve the Government's aim of bringing "far greater local ownership and involvement of patients, the public and staff".<sup>138</sup> It is also difficult to see how patient representation on the boards of particular local provider units fits with a developing world of extended patient choice of provider.

178. On the broader policy front, the omens for foundation hospital boards look even more uncertain. When we asked the Health Minister, Mr Hutton, about the origins and significance of foundation hospital boards (introduced during the passage of the Health and Social Care Act 2003) he told us "It probably would be true to say that we made that concession as the Bill progressed in Parliament because that is essentially what many of our colleagues asked us to do. They wanted to have that as part of the Bill. There was a history to that argument which I will not go into but I can understand why some people would make that observation".<sup>139</sup> Given the tone of this statement, it seems unlikely that the future of foundation hospital boards will be bright.

### *Sure Start boards*

179. A similar message has been detected in the Government's recently-announced plans to reform and expand the Sure Start scheme for 'early years' services for children and parents. One of the original features of Sure Start schemes was the role played by community boards, composed of representatives of parents, professionals and others working in very small and recognisable areas. The Government's new plans for Sure Start would mean the effective abolition of these boards and the transfer of much of their work to traditional local authorities, covering a much bigger geographical area. Some of those most closely involved in Sure Start have expressed concern at the Government's proposals to give the responsibility to allegedly remote bodies.

180. For example, the chairman of the Bellingham Sure Start board, responsible for the scheme in an area of south London, was critical of the Government's proposed changes. He

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<sup>138</sup> CVP 24a, para 25

<sup>139</sup> Q 474

feared that the quality of consultation would diminish “we’re going from a board that is one third parents or carers, a third community people and a third service providers to just an involvement panel”. He was concerned that parents would become “disillusioned and cynical” about the scheme as control slipped away to the distant town hall, and, significantly, that services would suffer.<sup>140</sup>

181. There are arguments to be made for both the “neighbourhood” and “traditional local government” approaches to representation. Whereas neighbourhood bodies may be more responsive to specific needs and may have a good understanding of the precise environment in which services are delivered, larger local authorities can offer a broader perspective, access to a wider range of professional expertise and greater democratic legitimacy.

182. Indeed there may be questions about the legitimacy of any new body for giving people a “voice” which is not grounded in recognised democratic institutions. Concern might be especially strong in cases where the new body is responsible for important functions such as the delivery of services or decisions regarding finance. Such a new body may well be, and seen to be, legitimate if its ‘constituency’ covers only those who are directly and self-evidently affected (for example, the tenants of a housing estate). But legitimacy may be more open to question in cases where the constituency cannot be so easily identified (for example, in the case of ‘patients’, who are urged to play their parts in the election of foundation hospital trusts).

183. We believe that there is a strong case for a programme of pilots of various approaches, followed by proper assessment of the benefits and disadvantages of different types of representative body. There is now a range of models available, and we would encourage further innovation. But the process has to be properly managed, integrated and evaluated.

**184. The Government needs a more coherent approach to the question of what is the most effective method of providing a representative voice for the user of public services. The uncertainties over Sure Start and foundation hospital boards raise questions about the voice of service users. The Government has welcomed innovation in the field of ‘choice’; it should equally welcome innovation in ‘voice’, initiating a programme of pilots to test and assess the merits of various models.**

## Voice and voting

185. Despite the Government’s positive words about the merits of local participation there are signs of a more fundamental Government scepticism about the practical usefulness of voice.

186. There are two ways of expressing voice through the ballot box: voting on a single issue referendum and voting for representatives, whether for foundation trust boards, parent governors, local councils, directly elected local mayors or national elections. Turnout at both local and national elections has decreased substantially over the last ten years. In its memorandum for this inquiry, the Government appears extremely sceptical about the

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<sup>140</sup> *Guardian Society*, 19 January 2005

value of democratically-elected representative bodies in improving standards in the public service, accusing them of being:

“often poor at dealing with under-performance. Voters are rarely faced with the costs of meeting their service requirements. When they are not faced with those costs, they can simply vote to increase or maintain services at other people’s expense. Indeed, this often happens when school or hospital closure proposals are put to a vote; the voters concerned usually do not have to bear the costs of keeping the institutions concerned open and in consequence usually vote the closure proposals down ... Whatever activists’ hopes and aspirations may be, in fact far fewer people are involved in expressing their views through formal mechanisms of ‘voice’, than through using services. And those that do tell us that there is much more to be done to make such mechanisms satisfying and effective”.<sup>141</sup>

“Parents who are dissatisfied with their local school, or patients with their local hospital, can vote for local elected representatives who are promising to provide better ones; but for their votes to be effective, a number of conditions have to be fulfilled. There has to be an election in the offing; their views have to be shared by a majority of other voters; the issues concerning the quality of schools or hospitals have to be the principal factors affecting the election; politicians promising better schools or hospitals have to be among the candidates; and, if these politicians are elected, they have to have some effective method for ensuring school or hospital improvement. It is rare that all of these conditions will be met”.<sup>142</sup>

187. Mr Nick Raynsford, ODPM Minister, also told us that “voice alone is probably not sufficient if you want to achieve really responsive public services”.<sup>143</sup>

188. The debate over tenant ballots on social housing options has raised some important questions about the value of voting in decisions on the future of public services, and Government and local authority attitudes to it. If the option being considered is transfer of the housing stock to a registered social landlord, then there is a requirement to ballot tenants. If the option is either to introduce an ALMO or PFI, there is no requirement for a ballot. In many local authorities, the consultation process has taken the form of ballots regardless of the options, and there have been some high profile examples, such as Camden and Birmingham, where tenants have voted against the option put to them. In Camden the tenants voted against an ALMO, and in Birmingham a 75% turnout voted two to one against stock transfer. Effectively, tenants appeared to be voting against improvements being made to their homes.

189. Elsewhere, such as in the London Borough of Newham, tenants have not been given a vote on stock transfer, but have been consulted by means of public meetings and a MORI survey. In Birmingham, after a ballot returned a ‘no’ vote, the Council is now consulting within individual neighbourhoods on smaller transfer agreements. Mr Wood, Newham’s Director of Housing, explained to the Committee his view that:

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<sup>141</sup> CVP 24, para 3.3.6

<sup>142</sup> CVP 24, para 3.3.7

<sup>143</sup> Q 479

“I do not think tenants should collectively be given the choice of landlord. My belief is that these are the State’s assets to provide housing for the current generation and for generations after. If the State chooses that it wants to re-mortgage or re-finance in order to bring this housing up to a standard and it has a responsibility to do that, then I think who owns the property, whether it is a housing association or the council, is not something that should be offered to tenants by way of choice. The only choice the tenants would have would be in an election where they would choose between one manifesto and another”.<sup>144</sup>

190. Thus at several levels of government there is dispute about the value of voting and of representative bodies on local service issues. The collective voice sounds uncertain.

### The role of complaints in making services responsive

191. If the situation of collective bodies is unsatisfactory, there are also shortcomings with the machinery for dealing with individual complaints. Large parts of the system for putting things right in public services need reform, but there is little early prospect of it. The Government notes in its evidence to the Committee that:

“Individual voice mechanisms such as complaints procedures also have their problems. They require energy and commitment to activate; they take a good deal of time to operate; and they create defensiveness and distress amongst those complained against. They favour the educated and articulate. Users who complain are not necessarily those who have the most to complain about; and adversarial relations between professionals and users, especially tied to a threat of lawsuits as they often are, can lead to expensive and inefficient defensive reactions on behalf of providers”.<sup>145</sup>

192. There are serious difficulties affecting the mechanism for handling NHS complaints. Ann Abraham, the Parliamentary and Health Service Ombudsman, told us of her serious concerns about the state of the system. She said that planned reforms were not being examined properly and that they contained significant flaws. Draft regulations covering the reforms “Focused on process and timescales rather than outcome, leadership and staff competence; failed to address the issue of redress for justified complaints; and included time targets which were not achievable for all complaints and so would result in disappointment and dissatisfaction”. She continued:

“I am concerned about the confusion caused to complainants by the delays in implementing these changes, the lack of preparedness for the new arrangements and the missed opportunities to deliver a patient-focused procedure”.<sup>146</sup>

193. The Ombudsman also told us of her anxiety that the Healthcare Commission, which is charged with handling many complaints under the new system, might be “overwhelmed”

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<sup>144</sup> Q 125

<sup>145</sup> CVP 24, para 3.3.9

<sup>146</sup> OMB 01

by the number of cases referred to it.<sup>147</sup> As with expanding choice, it is clear that providing more effective voice can be expensive in terms of both money and time.

194. More widely, the ability of Ombudsman systems to improve services is hampered by the relatively small number of cases that are dealt with by that route. It is difficult, although not impossible, to make suggestions for service reform based on such a limited evidence base. Ms Abraham said, however, that she would welcome a wider role in making the voice of the user heard:

“We have a lot of expertise in complaint handling, but the other thing we have is a huge amount of information going back many years now about the experience of patients and their families, what it feels like to be on the receiving end of the NHS complaints procedure, and that is what we can talk about in great depth and with quite a lot of feeling because my investigators are seeing those cases every day”.<sup>148</sup>

195. We are encouraged that the present Ombudsman is using the evidence she has received about the variations in funding for continuing adult care to make recommendations (now accepted) for a consistent national approach.<sup>149</sup> But this is a rare opportunity, offered by the exceptionally large number of relevant cases (600) that have made their way to the Ombudsman’s office.

196. Another constraint on the capacity of the Ombudsman system to strengthen the voice of the user is the fact that the office’s jurisdiction is restricted by the list of bodies that is laid before Parliament pursuant to the 1967 Act that governs her activities. This can have serious consequences, as was demonstrated when the Ombudsman was unable to investigate the activities of the Government Actuary’s Department in the case of Equitable Life. Ms Abraham told us that she would welcome a legislative change which would make it the presumption that central government bodies were within her jurisdiction, but she saw little chance of such a change being made in the near future.<sup>150</sup> We also support her call for the removal of the MP “filter” for Ombudsman cases, a proposal now supported by a clear majority of MPs in a recent survey undertaken jointly by the Ombudsman and by the Committee

**197. We repeat our earlier recommendation that the Government should move promptly to introduce legislation to remove the ‘MP filter’ on cases which are sent to the Parliamentary Ombudsman. There should be early action to modernise the system by which the Ombudsman’s jurisdiction is determined, so that it should become the presumption that her jurisdiction includes any central government body.**

## User surveys

198. There are a variety of ways in which those who provide services can discover the detailed views of service users. These can include: customer surveys, focus groups; and suggestion boxes or forms. Although there is no doubt that effective examples of all these

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<sup>147</sup> HC (2004–05) 50-i, Q 27

<sup>148</sup> *Ibid.*, Q 28

<sup>149</sup> *Ibid.*, Q 23

<sup>150</sup> *Ibid.*, Q 25

exist in the public sector, they seem to have been neglected in the current debate on the public services.

199. It is true that, in recent speeches, the Mr Alan Milburn has suggested that there are benefits in asking users directly for their opinions on services. He told the Social Market Foundation “Satisfaction levels with policing in the North West, for example, rose only after services in both Blackburn and Liverpool began to elicit public views on how performance could be improved. Many health and local authorities are finding the same. There are enormous gains to be made from bringing the public inside the decision-making tent”.<sup>151</sup>

200. Mr Milburn’s view was echoed by Ms Palmer-Fagan, Birmingham City Council, who told us that “As a district housing manager, I would not like to make any decisions in my district about changing that service without engaging and involving the people who I provider those services for”.<sup>152</sup> The South Birmingham Primary Care Trust also carries out “regular satisfaction surveys, focus groups, and patient forums with our service users” and felt that they “have made quite a lot of significant improvements in the services as a direct result of people saying ‘we would like things to be done this way, rather than this way’”.<sup>153</sup>

201. Whilst in Birmingham we also heard from Vic Smith, a tenants’ representative, that the transfer ballot appears to have prompted the Council to redouble its efforts to bring tenants into the decision-making process. Mr Smith told us that “we have been involved more since [the stock transfer ballot] than we ever were before ... The tenants have the chance to come and say what they want”.<sup>154</sup>

202. Schools operate a variety of “voice” mechanisms. Parents have a say through representatives on governing bodies and complaints systems. Parents are also often surveyed on proposed changes to schools such as the introduction of uniforms, and as part of OFSTED inspections. Pupils may have a voice through school councils. Martin Ward of the Secondary Head Teachers Association suggested to the Committee that an extension of pupil voice might be appropriate:

“It is possible to survey pupils and ask them whether they are content with their education. To move on from asking them about the dinners and state of the toilets to asking them about the lessons and the education process is a step that we are beginning to take now and we are beginning to see things like student governors and students involved in the appointment of teachers, for example”.<sup>155</sup>

203. When we considered the Ombudsman’s concerns about the new arrangements for the NHS complaints system last session, Sir Ian Kennedy, chair of the Healthcare Commission, told us:

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<sup>151</sup> Speech by Rt Hon Alan Milburn MP, 8 December 2004.

<sup>152</sup> Q 271

<sup>153</sup> Q 374

<sup>154</sup> Q 270

<sup>155</sup> Q 266

“I would say that, in concentrating on complaints, we forget that there are perhaps other interactions. I often talk about, if I may say so, the three Cs: compliments, comments and complaints—this is terribly rudimentary—and they are all part of one big C, which is communication”.<sup>156</sup>

204. In a subsequent memorandum, Sarah Mullally, the then Chief Nursing Officer, explained that

“The development of model patient comment cards was ... raised in ... *“NHS complaints reform—Making things right”*. This was published in March last year and follows our commitment in the NHS Plan that “all patients will be given the opportunity to record their views about the standards of care they have received...”. The development of patient comment cards is part of a broad range of initiatives discussed in *“Making things right”* to encourage more positive relationships between patients and healthcare professionals by both providing greater information to patients and actively seeking feedback from them.

... we have worked ... to develop a model comment card and supporting guidelines.

The comment card is seen as a means of collecting patient views, to ensure that NHS organisations can continually improve services using more immediate feedback, alongside information already obtained through the patient surveys and complaints. The comment cards will allow patients to say what was good or not so good about their treatment and make suggestions about what might be done to improve services”.<sup>157</sup>

**205. We commend comment cards as a straightforward but effective means for establishing user experiences from which the providers can learn and improve their service.**

206. The value of regular consultation of service users about their experiences and expectations of service delivery is clearly shown in Canada, where a biennial survey of 9,000 users across the provinces and territories is carried out by the Institute for Citizen-Centred Service (ICCS). The survey examines key “drivers” of satisfaction with services: timeliness; knowledgeable staff who go the extra mile to help clients, fair treatment; and a successful outcome. The 2002 survey found that timeliness, by a slight margin, was the lowest scoring in terms of satisfaction, but that it had the strongest impact on satisfaction, which suggests that in Canada improving timeliness presents the single biggest opportunity for service improvement. The same survey also examined the link between good services and confidence in government institutions, finding that “Good service not only makes citizens happy, it strengthens the institutions of government”.<sup>158</sup>

207. The ICCS also provides measures by which public satisfaction with individual services can be assessed. It is the custodian of a series of Common Measurement Tools which services can adapt and use in order to carry out individual surveys. The evidence from Canada is also becoming more widely known. When we visited that country in 2003 we

<sup>156</sup> HC (2003-04) 41-iii, Q 249

<sup>157</sup> OW 10

<sup>158</sup> ICCS, *Citizens First 3, Summary Report*, Institute of Public Administration of Canada, January 2003

were impressed by the commitment at both federal and provincial level to asking consumers what they needed and wanted from public services—and to making sure lessons were learnt to make sure they were improved (including targets for improved satisfaction levels over time). Writing in 2004 Mary Tetlow, principal adviser at the Office for Public Service Reform in this country, said that “The OPSR is now considering whether we should develop some aspects of the Canadian model here” as, although public service customer surveys are carried out in the UK, the UK lacks a common measurement tool. Ms Tetlow continued:

“Without [a common measurement tool] it is hard to gain a definitive picture of how well government is responding to the needs of customers across the whole public sector. What we need is a clear understanding of what matters to citizens about how public services are delivered and the key factors that will ensure that users of public services are satisfied with the experience...”<sup>159</sup>

208. The National Council for Voluntary Organisations (NCVO), representing the voluntary and not-for-profit sector, made a valuable point when it told us that “consultation should be about those things that the individual or the 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”.<sup>160</sup> There is a great deal of scope for innovation in the area of feedback about user preferences and levels of satisfaction with public services, and the Government should do more to encourage such innovation.

**209. We believe that there should be a more concerted approach to the measurement of public satisfaction with public services. The Canadian experience has shown that such an approach can be very useful in ensuring that lessons are learned and services improved along the lines that consumers require. Consideration should therefore be given to the development of a Public Satisfaction Index (PSI) which would be used to measure satisfaction with individual services. This should play a part in performance assessment and should be rigorously audited by an independent body such as the National Audit Office or Audit Commission.**

210. The machinery to allow service users to contact government departments and to communicate what they require is itself complex and variable in quality. It was found in March 2005 that there were no fewer than 198 call centres for central government alone.<sup>161</sup> As The Guardian commented “Does the DWP really believe that the public’s best interests are served by having 10 different contact centres for pension matters? Surely one would suffice?” In this area, choice does not seem likely to be what the public want of their public services. In France, there is a move to introduce a single access gateway, called ‘Allo Service Public’. The scheme aims to answer citizen’s administrative queries, satisfying 70% of requests straight away so users do not have to go elsewhere. The objective is to give a human and friendly service, as well as a modern image to public services. The development of a similar access gateway in the UK could help to make it easier for users to negotiate an

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<sup>159</sup> “The Canadian Experience”, *Public Finance*, January 2004

<sup>160</sup> CVP 07, para 4.17

<sup>161</sup> “Calling out around the world” *Public*, The Guardian, March 2005. The National Audit Office conducted a survey of government call centres in 2002: HC (2002–03) 134

increasingly complex world of public service delivery. **Building on the success of NHS Direct, we believe the trial of a Public Services Direct would be a valuable addition to the voice mechanisms available to users.**

### *A failure to listen to the voices of users*

211. We have identified shortcomings in the design and operation of the mechanisms which are supposed to give users a say in the direction of services. Neither complaints systems, representative bodies nor user surveys are sufficiently well developed or sensitive to the needs of the people who use services. One of the concerns raised by the Government about voice mechanisms is one which can also be levelled against choice-based systems—that they favour the “educated and articulate”.<sup>162</sup> It is ironic, and significant, that those who might be most disadvantaged by provider choice—the poor and the inarticulate—are often those who are also least able to take advantage of the “voice” they are given through the (often ineffective) representative bodies that currently exist. Their voices are rarely being heard.

212. It is therefore disappointing that the Government memorandum to the Committee, while acknowledging these difficulties, fails to offer any proposals for overcoming them. It appears that, within Government, policy development on choice has been given priority over policy development on voice, and that some important issues have been neglected. We hope that the recent initiatives from ODPM might help to overcome this deficit, but there is clearly much work still to do.

213. **We recognise that, just as there are constraints on choice, there are constraints on voice, whether expressed in representative bodies or through complaints systems and user surveys. More careful and imaginative consideration needs to be given to making voice mechanisms effective. The problems being encountered by the Parliamentary Ombudsman in gaining active and practical Government support for modernisation is one example of the current difficulties. Together, choice and voice can contribute to making public services responsive and giving more power and control to those that use them, but they must be treated with equal seriousness by the Government.**

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<sup>162</sup> CVP 24, para 3.3.9

## 6 Towards more responsive public services

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214. We have seen that there are weaknesses in two of the main pillars of the Government's current policy on public service reform. The Government's schemes for provider choice pose a range of practical difficulties which need to be overcome before choice can realise its undoubted potential to improve services, especially in the NHS. The prospects for other, less contentious forms of choice—broadly speaking, what we have described and in many cases commended as “choice from variety”—are good. The success of choice from variety depends on good management and leadership, good professional practice, and some extra resources. But choices of this sort need to be supported by sound methods for disseminating good practice, and success can be threatened, as we noted, wherever professionals are unable or reluctant to communicate properly with users.<sup>163</sup> As for strengthening the ‘voice’ of the citizen, the Government's policies are, as we have seen, not yet as robust or well-developed as they should be.

### Strengthening choice and voice: some examples

215. In this section, we examine some suggestions for making both choice and voice work better for the user of public services. The first group build on schemes that have proved to be useful either in this country or overseas. The second are more radical in their approach.

#### *Support for choice: Building on success*

##### *Patient Care Advisers*

216. It is clear that some public service users need help both in accessing information and in making choices. In the patient choice pilot schemes, the Government recognised this need and set up a system of Patient Care Advisers. As the Health Minister, Mr Hutton, told the Committee:

“We recognise that some people might need more help than others in making sense of that information and using it efficiently and effectively... Right at the core of that proposal around choice in CHD was patient care advisers, people who have the time, experience and knowledge to take patients through the various options which are open to them, to explain things about the different providers which are available to them so they can make informed and proper choices”.<sup>164</sup>

217. An evaluation commissioned by the Department of Health of the experience of patients involved in the CHD choice scheme found that: “The Patient Care Advisors played a key role in ensuring that patients had a positive experience of the scheme. They were an important point of contact and support and their role in smoothing patients' path through surgery was greatly appreciated”.<sup>165</sup> Those carrying out the evaluation went on to

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<sup>163</sup> See paras 96–98 above

<sup>164</sup> Q 391

<sup>165</sup> Picker Institute Europe (2003)

recommend that “Every patient offered Choice should be supported through the process by a PCA [Patient Care Adviser]”.<sup>166</sup>

218. Yet it seems that the Government has failed to learn the instructive lessons of the pilot schemes which have used patient care advisers. When asked what support would be provided for patients to help guide them through the new national patient choice scheme, Ministers have seen the issue as one for local decision. Mr Hutton, the Health Minister, said in February 2005 that “It is the responsibility of PCTs to provide or arrange targeted support for patients to help them make their choice of hospital”.<sup>167</sup> It appears that no earmarked extra funding will be provided from the Department of Health for any patient support. We are disappointed at this apparent failure to build support for patient choice into the new system. In particular, this lack of central guidance and action puts even more pressure on the GPs and others who, as we have seen, are not well-prepared to guide their patients through the choices they face.

**219. Patient care advisers have been crucial to the success of the pilot schemes for patient choice. It is clear to us that something similar, and indeed something rather more ambitious, would be of considerable benefit to those patients who are now offered the wider choice of hospital for elective surgery, and in particular those patients who are especially vulnerable and find the NHS system difficult to navigate. We are disappointed that the Government has not yet acted to ensure that adequate support and advice will be available. The Department of Health, working closely and consulting fully with local NHS bodies, should give urgent consideration to encouraging the provision of adequate support, through patient care advisers or other means, to make sure that some patients will not be disadvantaged by the introduction of NHS patient choice.**

### *The need for more Expert Patients*

220. We saw above (paragraphs 31-32) that the Expert Patients Programme gave those with long-term illnesses a chance to play a fuller role in their care and to share their experiences with others. As we noted, this offers an opportunity for patients to equip themselves with the information needed to work with clinicians in the management of their conditions.

221. The BMA responded with some enthusiasm to the introduction of EPP, saying that:

“This is a positive example of patients learning to manage their condition better, increasing confidence and enhancing their expression of preferences, and has the potential to combine the ethos of both active citizenship and customer oriented focus. The BMA supports the aim of this initiative and will follow its evaluation with great interest”.<sup>168</sup>

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<sup>166</sup> *Ibid.*

<sup>167</sup> HC Deb, 2 February 2005, col 995W

<sup>168</sup> CVP 18, para 18

222. An evaluation has concluded that EPP “was an effective and innovative means of managing chronic illness”, having the potential to “manage chronic conditions more effectively and engage hard to reach groups”.<sup>169</sup>

223. Yet the evaluation also says that “in most PCTs it was proving a challenge to introduce and establish EPP in the local health community and gain acceptance of it as a policy priority”. PCTs “felt EPP was a low priority and of marginal relevance to their core business”. Recruitment of patients has been slow and enthusiasm and recognition among professionals and GPs are limited. Damningly, the evaluation says that “professionals were viewed as non-receptive to the idea of user-led initiatives and EPP was considered a ‘priority’ which could easily be ignored”. The few thousand patients involved represent only a tiny fraction of the many millions who suffer from long-term conditions.

224. The story of EPP neatly encapsulates the unbalanced nature of the current debate on choice in public services. The EPP scheme is aimed at some of the most frequent and least healthy users of the NHS, and it is intended to improve their quality of life by equipping them with the skills they need to make informed choices about how their conditions are managed. Yet professionals do not feel that this ‘user-led’ programme is a priority. The resources of clinicians and managers are, it appears, focussed more on other issues, including the introduction of provider choice in elective surgery. Our perception is that much more could be done, by Ministers, professionals and managers, to make a success of EPP.

**225. The Government should urgently examine the scope for an expansion of the Expert Patients Programme. EPP is an important and innovative way in which patients can equip themselves with the information and expertise needed to strengthen their hand in the era of choice. It needs to be promoted by the Government with much greater vigour and commitment.**

### *Improving school choice through lotteries*

226. We noted above (paragraph 87) that the location of a child’s home often effectively restricted his or her choice of school. Philip Collins saw one way to correct this imbalance: “The only way you can sort that out is for the whole area to be the catchment area and, if one school is over-subscribed, the only fair mechanism for sorting people out is a lottery”.<sup>170</sup>

227. Lotteries are in use by a small number of schools in England. Stephen Twigg MP, Schools Minister, told us of one example, the Lewisham Academy in London which he described as a “struggling school”, where 50% of its places on over-subscription are allocated by lottery within a wide catchment area.<sup>171</sup> The Chief Schools Adjudicator, Dr Hunter, told us that he had recently approved a lottery for places at a school in Brighton, and that there was “nothing to stop a school using a lottery if that is what it wants to do”.<sup>172</sup>

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<sup>169</sup> National Primary Care Research and Development Centre, *National Evaluation of the Expert Patients Programme: Assessing the Process of Embedding EPP in the NHS: Preliminary Survey of PCT Pilot Sites*, January 2004

<sup>170</sup> Q 15

<sup>171</sup> Q 490

<sup>172</sup> Q 211

However, whilst good schools can exercise selection through catchment area, no real incentive exists for schools to hold lotteries. It is currently a matter for schools admissions authorities themselves to set admissions procedures which are in line with government guidelines on objectivity and fairness. **The experience of school lotteries in the USA suggest that there should be further exploration by the Government of the use of that method of allocating places in this country.**

### *Progressive school vouchers*

228. Professor Brighthouse, who told us that choice based systems can be designed to combat cream-skimming and promote equity, favoured the option of progressive school vouchers. For schools admissions he proposed “a progressive voucher-like mechanism, providing much higher per-pupil funding for high-need children, regardless of the school they attend would help to level the playing field”. He went on to support a system where “low-income children should receive 300% of the regular per-pupil funding, at least in metropolitan areas”.<sup>173</sup> This system would be similar to that used in Milwaukee in the United States. It would make the more difficult service users more attractive to providers, changing the basis of school selection. The Government has indicated that all schools should be prepared to accept a proportion of challenging children.<sup>174</sup> It has not, however, yet fully resolved the issue of how to make that happen in practice. Despite proposing the extension of choice schemes, the Government memorandum explains that “the policy challenge is to identify which of these options is likely to be most effective and consistent with other government policies”.<sup>175</sup> **We believe that progressive vouchers should be given serious consideration as one way of combining choice with equity.**

### *Entitled to choice, entitled to high standards*

229. While there is merit in using such methods to mitigate the ill effects which might follow from an extension of provider choice, there are also other, more radical ways to use choice to increase equity and to support a range of other goals of public service.

230. An important underpinning to the notion of choice in public services is the principle that service users not only have a right to choose the sort of service they want, but also a right to expect at least a guaranteed minimum standard of service when they make that choice. A choice between several poor schools or hospitals would, of course, be no real choice at all. Choice and rights need to go together.

231. The idea that citizens should be entitled to certain minimum standards in the provision of public services and to have the means to hold service providers or public bodies to account for this has been long in development. The Parliamentary Commissioner Act 1967 first introduced the concept of maladministration and redress with regard to public bodies. The Citizen’s Charter represented a further refinement of the idea that users of public services should not be mere recipients but should enjoy legitimate expectations about the quality and efficiency of those services.

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<sup>173</sup> CVP 23

<sup>174</sup> DfES, Press Release, 18 November 2004

<sup>175</sup> CVP 24, para 3.5.15

232. The introduction of Public Service Agreements in Whitehall with their targets and associated investment were themselves accompanied by the unheralded service delivery agreements (SDAs) of lower level, more output specific targets. However, developing ideas about entitlements to quality services give rise to two issues: how to measure that performance and what to do if there is a failure to meet it?

### *Building on the Citizen's Charter?*

233. The Citizen's Charter lost public respect because it was seen as being too confused in its objectives. However the basic idea, that public services should operate at a minimum standard of performance, whatever the provider, is one that has survived and, to an extent, prospered. Its current incarnation, the Charter Mark, is "the government's national standard for customer service for organisations delivering public services, independently and rigorously evaluated and assessed".<sup>176</sup> The Charter Mark is both a standard setting mechanism and also an assessment tool with external, independent certification. It is widely applied with over 2,000 organisations and public bodies operating to it. To obtain a Charter Mark organisations are expected to meet six criteria:

- set standards and perform well;
- actively engage with your customers, partners and staff;
- be fair and accessible to everyone and promote choice;
- continuously develop and improve;
- use your resources effectively and imaginatively; and
- contribute to improving opportunities and quality of life in the communities you serve.

### **Creating entitlements to good quality public services**

234. Writing about the work of Public Service Users Forum, Ed Mayo, Chief Executive of the National Consumer Council, identified five best approaches to giving service users rights:

- giving clear guarantees on service quality and availability. The right to a poor service, after all is not a good right;
- not being necessarily legal rights, but are capable of being enforced;
- providing for redress if things go wrong which adequately compensates the user and gives the organisation an incentive to live up to the performance promise;
- being well-publicised and shaped and improved by the individual and collective voice

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<sup>176</sup> Cabinet Office, *Charter Mark Standards*, April 2004

of users; and

- connecting the promotion of rights with the uptake of responsibilities.<sup>177</sup>

235. The introduction of Public Service Agreements (PSAs) after 1997 was a product of a different culture from that of the Citizen's Charter. PSAs have been centrally-set frameworks of targets which aim to ensure that the large investment in public services secure the desired policy outcomes. However, because of this, they sought to impose a discipline and accountability on the provider rather than enhancing the power and control which can be exercised by the user. The effect on users and citizens was at best indirect, and in some ways PSAs have undermined the good work of the Citizen's Charter by focusing attention again on to the demands of the centre and away from the needs of the user.

236. If the Government's legitimate wish to ensure that its expenditure is matched by improvements in public services is to be reconciled with users' expectations about the level of service they can expect, marrying the two approaches becomes necessary. Together they can create entitlements to good quality public services which yield beneficial outcomes.

237. The Government's choice agenda strengthens some of these connections. The Department of Health's PSA target of substantially reducing mortality rates by 2010 (in the case of heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole) is supported by the cardiac patient choice initiative which provides the choice of faster treatment at another hospital to patients who have waited over six months for heart surgery.

238. Until the Spending Review 2004, there was some attempt to achieve this by parallel sets of SDAs. The Treasury, in line with our report on Targets, sought to reduce and focus its target-setting process. The 2003 Pre-Budget Report announced the abolition of SDAs. In the Spending Review 2002, these SDAs comprised over 500 subsidiary targets focused on the process of delivery rather than outcomes. The Treasury contend that, removing the requirement for departments to set and agree SDAs, provides more scope for departments to devolve decision-making and maximise local flexibility to deliver.

### **Public service guarantees**

239. However, consideration should be given to the case for a new form of service delivery agreement which can become the means to deliver public service 'guarantees' or entitlements within the framework of spending plans. These guarantees would take a variety of forms to reflect the diversity of service provision. Some models already exist. The NHS patient choice pilots were built on a platform of rights to treatment within a specified period. We have discussed the Charter Mark. Ed Mayo also noted the development of community service agreements which offer community groups rights to funding if they

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<sup>177</sup> Ed Mayo, *Public*, February 2005

can demonstrate success in reducing crime rates through preventive actions. Home/School Agreements have been in place for some years now. They encompass both the rights of parents and pupils should enjoy as part of their school life as well as the obligation they are expected to meet.

240. The latest model was brought forward in February 2005 by the Deputy Prime Minister. These are the neighbourhood charters which he announced as part of his proposals for a stronger local voice. They combine 'choice' and 'voice' by giving people the right to demand that services reach the standard they require.<sup>178</sup> Consideration might also be given to the scope for using guarantee more radically to inspire progress in services where the Government—along with many users—identifies a particular need for improvement. For those living in areas where there are severe and long-term shortages of NHS dentists, for example, some form of financial redress, perhaps through the tax system, might be considered if improvement targets are not met. Similarly, if schools are unable to offer adequate special needs provision for those with specific learning difficulties there should be a right to access to alternative providers.

241. There are also a number of possible international models. School choice in the USA has recently been extended by the *No Child Left Behind Act 2001* which initiated a new federal approach to education in the United States. The Act requires each state to define the minimum levels of improvement for schools. If a school which receives federal funds to improve the academic achievement of low income families fails to improve they are subject to an action plan and timetable set out by the legislation. After two years without making adequate progress the pupils are offered the option of transferring to another public school in the district that has not been identified as needing improvement. The school will also have to develop a plan to turn the school around. If the school does not make adequate progress for three years, the district must also offer students from low-income families supplemental education services, such as tutoring or remedial classes, from a state-approved supplier. In the fifth year the school must initiate plans for restructuring itself.

**242. With all these models available, it should be possible to devise a developing set of Public Service Guarantees (PSGs) which may apply either nationally or locally and which would be pledges of services being provided to a minimum standard. They would:**

- support policy outcomes;
- be precise as to the level of service to be expected (e.g. an operation in six months, or a passport in six weeks);
- have a clear statement that the service could be delivered by a provider of the user's choice; and
- clear arrangements for redress in the event of failure.

243. Public service guarantees would be a radical development, but one that would focus public services firmly on the user. If they were devised and applied locally, they would also

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<sup>178</sup> See para 43 above

support the development of a stronger and more credible voice, raising the profile and enhancing the credibility of local representative bodies.

### Monitoring performance

244. If there are to be public service guarantees, the standards on which they are based need to be robust, and the level of performance against them widely agreed. Monitoring of the highest quality will be necessary if the guarantees are to be effective. Indeed, one of the strongest objections we heard on our visit to the USA of the federal *No Child Left Behind* programme was that standards and the rigour of their application varied considerably from state to state. This made it difficult to claim that children were being treated equitably. Some schools which would be assessed as failing in one state would be judged to be working efficiently in another. Children would therefore benefit from the guaranteed choice available through *No Child Left Behind* in one state, while equally deserving children in another state would be turned down. Giving evidence to us the Ombudsman agreed with the idea of performance standards:

“Yes, there should be service standards and, yes, there should be methods of monitoring those service standards to ensure that they are either complied with or made into something that can be delivered. ... the expectations of good customer service need to be articulated and adhered to”.<sup>179</sup>

245. She considered that one possibility to ensure compliance was to have a “strategic alliance” of the various bodies that have these sorts of roles [monitoring] in relation to government and public service providers can join up in assisting with the monitoring as well”.<sup>180</sup> The Audit Commission has been operating its Comprehensive Performance Assessments for local authorities, and it is growing in reputation. The increasing importance of such technical quality assessments, even in the inevitably political field of local government, was acknowledged with refreshing candour by the Minister, Mr Raynsford, in his evidence to us:

“It is an interesting and difficult question for anyone who stands on a party ticket, but let me just say that I do not think local government has been well served in the past by a tendency to vote the party ticket irrespective of performance. It has been particularly depressing for councillors who have run their council well to find that they have been voted out of office because their party has been unpopular at a national level. I think it is right that people should be able to differentiate more, and processes like the comprehensive performance assessment do give information that enable the public to differentiate more”.<sup>181</sup>

**246. If public service guarantees are to be credible, they will need to be monitored by a range of bodies which would co-operate to ensure that compliance with performance standards is measured accurately, and that their recommendations for improvement have authority. We are attracted by the idea of a “strategic alliance” of such bodies, which would include the PCA, NAO, the Audit Commission, OFSTED, the Healthcare**

<sup>179</sup> HC (2004–05) 50-i, Q 33

<sup>180</sup> *Ibid.*

<sup>181</sup> Q 481

**Commission and others. This would develop common principles and share best practice to inform the work of all the inspecting bodies. The general issue of coherent performance monitoring, across all public services, and the most appropriate organisational arrangements to service this, is one to which the Committee will return.**

247. The Government is right to want to give the user more control over public services, whether through choice mechanisms of different kinds or through new forms of voice. However, it is important that choice and voice are seen as complements, not alternatives, and that the design features of both are consistent with key public service principles. There is much scope for innovation and learning in relation to both choice and voice, just as there is ample scope for rhetoric and confusion. In this report we have tried to encourage the former and avoid the latter, as the route to genuine public service reform.

## Conclusions and recommendations

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### Choice

1. The evidence suggests that, while choice is regarded by the public as an important feature of good public services, it is not necessarily their highest priority. Such schemes as direct payments for social care and choice-based lettings demonstrate that users often value the opportunity to take charge of certain decisions about services and to exercise greater power, control and choice in their lives. Some of the most frequent users of public services appear to place greater emphasis on practical choices which have a direct and immediate impact on their quality of life than on the choice of service provider. (Paragraph 142)
2. We believe that some of the problems with choice would be eased if there was more acknowledgement of its limitations. Rhetoric does not match the reality. Too often the 'choice' label is applied to schemes in which the most the consumer can hope for is second, third or even fourth choice. It should always be made clear to people what they can realistically expect from the choices they are offered. (Paragraph 144)
3. Secondary schools find it difficult to respond flexibly to the demand generated by parental choice. It is unrealistic to expect schools to expand and contract in the way that is sometimes suggested. Nevertheless, educational choice, especially choice of subject, can be enhanced by imaginative collaborations and partnerships between schools which make the most rational use of resources. (Paragraph 146)
4. We believe that the evidence shows that specific, limited and targeted schemes for provider choice, such as the London Patient Choice Project and the Coronary Heart Disease Choice scheme make effective use of NHS capacity. They demonstrate that well-designed schemes can help the NHS put choice of provider to good use for the benefit of patients. However, recent ministerial comments about the potential for hospital closures in the era of patient choice raise serious concerns about the future of local service provision, and indeed about the future overall capacity of the NHS. Private hospitals have few additional resources to offer, as most of their major operations are carried out by surgeons who also work in the NHS. (Paragraph 148)
5. The introduction of choice-based lettings has eased the process by which tenants are matched with suitable accommodation, and has enabled tenants to take more control. However, there are limits to the amount of popular housing available, and tenants' first choices often cannot be met. The limitations as well as the benefits of such schemes need to be recognised. (Paragraph 150)
6. We have concluded that choice can be consistent with equity, but only if schemes are well-designed and motivated by a desire to reduce unfairness. We believe that certain types of selection by provider in a public service can be incompatible both with equity and with the principle of choice for the user. The Government should, in particular, consider the effects on its wider objectives of selection by schools. (Paragraph 154)

7. We believe that costs as well as benefits result from the creation of markets and especially the use of private provision in systems to enhance choice in public services. The NHS, for example, is still coming to grips with the implications of the guaranteed level of private sector provision in the current patient choice scheme, and it is likely that it will, to an extent, prove to be wasteful of NHS resources. This effective transfer of commercial risk to the NHS will need very careful monitoring. If necessary, the design of the patient choice system will need to be changed, perhaps with less emphasis on guarantees for private providers. (Paragraph 157)
8. The Government's plans to prevent the practice of "cream-skimming" by private providers of public services appear to us to be sketchy and inadequate. Ministers need to make an urgent effort to ensure that private providers do not exploit choice schemes to the detriment of the public interest. (Paragraph 158)
9. The Government should also consider the broader public administration implications in cases where direct public provision of services is brought to an end. In particular, Ministers should consider: the effects of the loss of in-house expertise and infrastructure, which can make it difficult to monitor contracts; the earmarking of funds for private contracts for several years ahead, which can bind successors and restrict their ability to set suitable priorities in the public interest; and a loss of knowledge and learning that comes from the removal of direct contact with users. (Paragraph 159)
10. We consider that there is the potential for conflict between two central goals of Government policy: the drive to produce efficiency savings and the desire to expand choice for the users of public services. It is also disturbing that there are continuing doubts about the effectiveness and efficiency of the financial and computer systems on which the NHS is basing patient choice. (Paragraph 161)
11. We consider that the evidence about the effect on the overall performance of public services of the introduction of greater choice is still scarce and inconclusive. The pilot schemes in health which have been evaluated give some grounds for optimism, but their results will not necessarily read across to the much larger national schemes which are now being introduced. The evidence from the USA and elsewhere on education choice suggests that some schemes are effective while others are not. Choice on its own does not deliver better performance, although it may help. (Paragraph 163)
12. Local government can do much on its own initiative to offer more choice to the users of public services. Although some councils may be resisting reform, much innovative work is being done at local level. However, local authorities do not always believe that they receive the appropriate credit and support from central government. The Government must ensure that local government is fully engaged in all relevant aspects of the design of schemes to increase choice. (Paragraph 165)
13. We conclude that the Government needs to look more carefully at the detailed design and implementation of schemes for user choice. Evidence from the front line of public services suggests that greater provider choice in NHS healthcare is being introduced with insufficient attention to the need to win the acceptance of either

users or staff. We hope that the reforms being carried out to the system by which parents choose secondary schools will be effective in reducing the inequities and distortions which have arisen in the system. (Paragraph 166)

14. The Government needs a more coherent approach to the question of what is the most effective method of providing a representative voice for the user of public services. The uncertainties over Sure Start and foundation hospital boards raise questions about the voice of service users. The Government has welcomed innovation in the field of 'choice'; it should equally welcome innovation in 'voice', initiating a programme of pilots to test and assess the merits of various models. (Paragraph 184)

## Voice

15. We repeat our earlier recommendation that the Government should move promptly to introduce legislation to remove the 'MP filter' on cases which are sent to the Parliamentary Ombudsman. There should be early action to modernise the system by which the Ombudsman's jurisdiction is determined, so that it should become the presumption that her jurisdiction includes any central government body. (Paragraph 197)
16. We commend comment cards as a straightforward but effective means for establishing user experiences from which the providers can learn and improve their service. (Paragraph 205)
17. We believe that there should be a more concerted approach to the measurement of public satisfaction with public services. The Canadian experience has shown that such an approach can be very useful in ensuring that lessons are learned and services improved along the lines that consumers require. Consideration should therefore be given to the development of a Public Satisfaction Index (PSI) which would be used to measure satisfaction with individual services. This should play a part in performance assessment and should be rigorously audited by an independent body such as the National Audit Office or Audit Commission. (Paragraph 209)
18. Building on the success of NHS Direct, we believe the trial of a Public Services Direct would be a valuable addition to the voice mechanisms available to users. (Paragraph 210)
19. We recognise that, just as there are constraints on choice, there are constraints on voice, whether expressed in representative bodies or through complaints systems and user surveys. More careful and imaginative consideration needs to be given to making voice mechanisms effective. The problems being encountered by the Parliamentary Ombudsman in gaining active and practical Government support for modernisation is one example of the current difficulties. Together, choice and voice can contribute to making public services responsive and giving more power and control to those that use them, but they must be treated with equal seriousness by the Government. (Paragraph 213)

## Towards responsive public services

20. Patient care advisers have been crucial to the success of the pilot schemes for patient choice. It is clear to us that something similar, and indeed something rather more ambitious, would be of considerable benefit to those patients who are now offered the wider choice of hospital for elective surgery, and in particular those patients who are especially vulnerable and find the NHS system difficult to navigate. We are disappointed that the Government has not yet acted to ensure that adequate support and advice will be available. The Department of Health, working closely and consulting fully with local NHS bodies, should give urgent consideration to encouraging the provision of adequate support, through patient care advisers or other means, to make sure that some patients will not be disadvantaged by the introduction of NHS patient choice. (Paragraph 219)
21. The Government should urgently examine the scope for an expansion of the Expert Patients Programme. EPP is an important and innovative way in which patients can equip themselves with the information and expertise needed to strengthen their hand in the era of choice. It needs to be promoted by the Government with much greater vigour and commitment. (Paragraph 225)
22. The experience of school lotteries in the USA suggest that there should be further exploration by the Government of the use of that method of allocating places in this country. (Paragraph 227)
23. We believe that progressive vouchers should be given serious consideration as one way of combining choice with equity. (Paragraph 228)
24. With all these models available, it should be possible to devise a developing set of Public Service Guarantees (PSGs) which may apply either nationally or locally and which would be pledges of services being provided to a minimum standard. They would: support policy outcomes; be precise as to the level of service to be expected (e.g. an operation in six months, or a passport in six weeks); have a clear statement that the service could be delivered by a provider of the user's choice and clear arrangements for redress in the event of failure. (Paragraph 242)
25. If public service guarantees are to be credible, they will need to be monitored by a range of bodies which would co-operate to ensure that compliance with performance standards is measured accurately, and that their recommendations for improvement have authority. We are attracted by the idea of a "strategic alliance" of such bodies, which would include the PCA, NAO, the Audit Commission, OFSTED, the Healthcare Commission and others. This would develop common principles and share best practice to inform the work of all the inspecting bodies. The general issue of coherent performance monitoring, across all public services, and the most appropriate organisational arrangements to service this, is one to which the Committee will return. (Paragraph 246)

## Formal minutes

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**Thursday 10 March 2005**

Members present:

Tony Wright, in the Chair

Mr David Heyes

Mr Kelvin Hopkins

Mr Ian Liddell-Grainger

Mr Gordon Prentice

Brian White

Iain Wright

The Committee deliberated.

Draft Report (Choice, Voice and Public Services), proposed by the Chairman, brought up and read.

*Ordered*, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 247 read and agreed to.

Summary agreed to.

*Resolved*, That the Report be the Fourth Report of the Committee to the House.

*Ordered*, That the Chairman do make the Report to the House.

*Ordered*, That the provisions of Standing Order No. 134 (Select Committees (reports)) be applied to the Report.

*Ordered*, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Thursday 17 March at 10.00am

# Witnesses

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## Thursday 18 November 2004 (HC 1263-i)

**Lord Blackwell**, Centre for Policy Studies, **Mr Phil Collins**, Social Market Foundation, **Sir Christopher Gent** and **Mr Nick Herbert**, Reform Ev 6

**Rt Hon Lord Hattersley** Ev 18

## Thursday 25 November 2004 (HC 49-i)

**Dr Tim Brown**, De Montfort University, **Mr Alan Walter**, Defend Council Housing and **Mr Chris Wood**, Newham Borough Council Ev 43

**Professor Allyson Pollock**, University College, London, **Mr James Johnson**, BMA Council, **Mr John Appleby** and **Mr Niall Dickson**, King's Fund Ev 70

## Thursday 13 January 2005 (HC 49-ii)

**Professor Harry Brighouse**, University of Wisconsin, **Dr Philip Hunter CBE**, Chief Schools Adjudicator and **Mr Martin Ward**, Secondary Heads Association Ev 91

## Tuesday 18 January 2005 (HC 49-iii)

**Mr Vic Smith**, **Ms Helen Marson**, **Ms Carolyn Palmer-Fagan** and **Ms Revinder Johal**, Birmingham City Council Ev 104

**Mr Chris Palmer**, **Mr Tony Howell**, Birmingham City Council, and **Mr Tim Boyes**, Queensbridge School Ev 112

**Mr Peter Hay**, Birmingham City Council, **Mr Graham Urwin**, **Ms Chris Fearn** and **Ms Doreen Harrison**, South Birmingham Primary Care Trust Ev 119

## Thursday 20 January 2005 (HC 49-iv)

**Rt Hon John Hutton MP** and **Mr John Bacon**, Department of Health Ev 141

## Thursday 27 January 2005 (HC 49-v)

**Mr Stephen Twigg MP**, Department for Education and Skills and **Rt Hon Nick Raynsford MP**, Office of the Deputy Prime Minister Ev 169

## List of written evidence

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### Published in this volume:

Reform (CVP 16)	Ev 1
Rt Hon Lord Hattersley (CVP 15)	Ev 18
Dr Tim Brown, Director, Centre for Comparative Housing Research, De Montfort University (CVP 17)	Ev 27
Defend Council Housing (CVP 5, CVP 5(a))	Ev 33, 38
Professor Allyson Pollock (CVP 20)	Ev 53
British Medical Association (CVP 18)	Ev 55
King's Fund (CVP 19)	Ev 61
Philip Hunter, Chief Schools Adjudicator (CVP 21)	Ev 78
Secondary Heads Association (CVP 22)	Ev 80
Professor Harry Brighouse, University of Wisconsin (CVP 23)	Ev 83
Minister of State (Health) at the Department of Health; Minister of State for Local and Regional Government; and Minister of State for School Standards (CVP 24)	Ev 127
Minister of State (Health) (CVP 24 (a), CVP 24 (d))	Ev 137, 160
Minister of State for Local and Regional Government (CVP 24 (b))	Ev 162
Minister of State for School Standards (CVP 24 (c))	Ev 167
Professor Ron Glatter, Centre for Educational Policy, Leadership and Lifelong Learning (CEPoLL), Faculty of Education and Language Studies, The Open University (CVP 02(a))	Ev 185
Public and Commercial Service Union (PCS) (CVP 25)	Ev 185

### Published in HC 49-II:

Sainsbury Centre for Mental Health (CVP 01)	Ev 1
Professor Ron Glatter (CVP 02)	Ev 4
Democratic Health Network (CVP 03)	Ev 10
National Consumer Council (CVP 04)	Ev 14
Local Government Information Unit (CVP 06)	Ev 18
NCVO (CVP 07)	Ev 21
Royal College of Nursing (CVP 08)	Ev 26
New Local Government Network (CVP 09)	Ev 32
Catherine Needham, Queen Mary, University of London/Catalyst (CVP 10)	Ev 36
Audit Commission for Local Authorities and the National Health Service in England and Wales (CVP 11)	Ev 40
National Audit Office (CVP 12)	Ev 60
Business Services Association (CVP 13)	Ev 75
London Borough of Camden (CVP 14)	Ev 77

# Reports from the Public Administration Select Committee since 2001

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## Session 2004–05

First Report	Government by Inquiry	HC 51–I
Second Report	Work of the Committee in 2004	HC 306
Third Report	Response to the Government’s Consultation on the Civil Service Bill	HC 336
Fourth Report	Choice, Voice and Public Services	HC 49–I

## Session 2003–04

First Report	A Draft Civil Service Bill: Completing the Reform	HC 128–I ( <i>Cm 6373</i> )
Second Report	The Work of the Committee in 2003	HC 229
Third Report	Ministerial Accountability and Parliamentary Questions	HC 355 ( <i>HC 1262</i> )
Fourth Report	Taming the Prerogative: Strengthening Ministerial Accountability to Parliament	HC 422 ( <i>Cm 6187</i> )
Fifth Report	A Matter of Honour: Reforming the Honours System	HC 212–I ( <i>Cm 6479</i> )
First Special Report	Ministerial Accountability and Parliamentary Questions: Government Response to the Committee’s Third Report of Session 2003–04	HC 1262

## Session 2002–03

First Special Report	The Public Service Ethos: Government’s Response to the Committee’s Seventh Report of Session 2001–02	HC 61
First Report	Ministerial Accountability and Parliamentary Questions: The Government Response to the Ninth Report from the Committee (Session 2001–02)	HC 136
Second Report	The Work of the Committee in 2002	HC 447
Third Report	Ombudsman Issues	HC 448 ( <i>Cm 5890</i> )
Fourth Report	Government By Appointment: Opening up the Patronage State	HC 165–I
Fifth Report	On Target? Government By Measurement	HC 62–I ( <i>HC 1264</i> )
Sixth Report	On Target? Government By Measurement: the Government’s Response to the Committee’s Fifth Report	HC 1264

## Session 2001–02

First Report	Public Participation: Issues and Innovations: The Government Response to the Committee’s Sixth Report of Session 2000–01	HC 334
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Second Report	The Ministerial Code: Improving the Rule Book: The Government Response to the Committee's Third Report of Session 2000–01	HC 439
Third Report	Special Advisers: Boon or Bane: The Government Response to the Committee's Fourth Report of Session 2000–01	HC 463
Fourth Report	Ministerial Accountability and Parliamentary Questions: The Government Response to the Committee's Second Report of Session 2000–01	HC 464
Fifth Report	The Second Chamber: Continuing the Reform	HC 494–I ( <i>HC 794</i> )
Sixth Report	The Second Chamber: Continuing the Reform: The Government Response to the Committee's Fifth Report	HC 794
Seventh Report	The Public Service Ethos	HC 263–I ( <i>HC 61</i> )
Eighth Report	"These Unfortunate Events": Lessons of Recent Events at the Former DTLR	HC 303–I ( <i>Cm 5756</i> )
Ninth Report	Ministerial Accountability and Parliamentary Questions	HC 1086 ( <i>HC 136</i> )

The response to the report is printed in brackets after the HC printing number.