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## Response

# The case against choice and competition

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**Abstract:** Choice and competition are central planks of the English government's health reforms and modernisation programme. Wales and Scotland have chosen a different path, which calls into question the suggestion that in an age of consumerism there is no other way to secure overdue changes in the provision and management of health care to improve their quality and responsiveness to user preferences. Yet pro-market enthusiasts pursue their agenda in the face of evidence that calls into question the claims they make. It is a curious position for a government that is wedded to evidence-based policy to find itself in. The policy puzzle is why, despite the contested nature of the alleged virtues of choice and competition, policy-makers persist with introducing a set of reforms which appear to threaten the very values and principles they profess to uphold. An alternative reform paradigm exists which acknowledges what makes public services public. This paper sets out the key features of what rediscovering public service entails adopting the notion of co-production as a means of bringing about a new relationship between professionals and the public that remains true to the National Health Service's social purpose.

Reading Julian Le Grand's book, *The Other Invisible Hand*, is an uncomfortable experience for anyone opposed to its thrust. The easy and accessible prose is positively beguiling and seductive in its elegance, simplicity, rationality and seemingly non-ideological stance. The arguments (and evidence such as it is) are carefully deployed and counter-arguments are politely, if firmly, demolished. The impression given is that through choice and competition a near-perfect world of health care beckons, and certainly one that is a marked improvement on what already exists.

If the real world of health policy and politics were less messy and complex, then perhaps Le Grand's thesis would carry more appeal and conviction. But this is surely the crux of the matter for analysts puzzling to comprehend the

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appeal of choice and competition among policy-makers and their advisers, Le Grand among them. Take the conclusion of one analyst from an extensive review of the evidence regarding the development of the US health care market from 1993 to 2005. Throughout this period, "market behaviour reflected fundamentals of supply and demand or potential profit only as refracted through, so sometimes distorted by, stories that were told in the health policy and investment communities" (White, 2007: 18). The frequent inaccuracy of these stories should give pause to anyone who believes the market is somehow rational and neutral in its transactions. Indeed, the causes of the economic recession that has engulfed market-based economies have much to do with the dysfunctional and toxic features of competition combined with weak regulation. And to those who insist that what applies in the US would not apply here, why should anyone believe them when many of the companies White refers to are seeking opportunities to extend their operations into the UK.

Despite evidence to the contrary, health ministers stubbornly hold to the view that there is no other way. But why? Surely they cannot be basing their arguments on the evidence which is highly contested and by no means conclusive, as even Le Grand acknowledges in his contribution to this Debate. Sadly, the symposium convened to discuss Le Grand's book excepted, instead of encouraging a grown-up public discourse about such matters, opposition is prematurely closed down and countervailing views are simply not taken seriously. Instead, they are dismissed as coming from vested interests that simply want to preserve their perks and privileges, and dislike change. Or they are rejected as the fevered imaginings of unreconstructed Old Labour supporters, and/or ideologically suspect social scientists who can easily be discounted as romantics harking back to a mythical 'golden age'. Sensible left leaning policy-makers, on the other hand, have come to regard choice and competition as having a "potential positive impact. . .on equity" and have been persuaded that they offer "better quality and less inequity than traditionally collectivist public health systems" (Cooper and Le Grand, 2007: 18).

It therefore seems that there is only one way to improve health and the quality of care, and that choice and competition have become central planks of that mission – at least in England. Significantly, two of the other countries making up the UK – Wales and Scotland (Northern Ireland has yet to declare its hand on health) – have chosen a different path, and an even greater policy divergence in future seems likely (Greer, 2008).

Of course, it is quite possible to have choice without competition, and competition without allowing choice. However, the two are generally regarded as going hand in hand since choice without competition may result in people having an insufficient range of options from which to choose – the dilemma of choosing any colour as long as it is black. And competition without choice is seen as unworkable unless there is a mechanism whereby people can exercise not merely voice, if they do not perceive themselves to

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be getting a good service, but also exit by taking their health problems elsewhere. Opponents of choice are invariably, though by no means always, also opposed to competition believing that both market-style mechanisms pose serious risks for the ethos and values of a public health service. In particular, they threaten to destabilise the principle of universal access to care and impact negatively on equity.

This article puts the case against both choice and competition in health care. In their place, it offers an alternative road map to improved health and health care – one that rejects the growing marketisation and commodification of health care. Readers seeking an extended discussion of both themes are referred to my recent book, *The Health Debate* (Hunter, 2008).

## The limits to markets

The limits to markets in health care have been well documented, especially in the celebrated article by Kenneth Arrow (Arrow, 1963). They were usefully summarised in a lecture Gordon Brown, now prime minister, gave when Chancellor of the Exchequer to the Social Market Foundation in 2003 (Brown, 2004). Critical of markets in health care, and by implication the then prime minister's attraction to them, Brown concluded his analysis of market failure by proposing that reforming and modernising the public realm did not need to rely on market mechanisms but should be achieved through devolution, transparency and accountability. He maintained that "the assumption that the only alternative to command and control is a market means of public service delivery has obscured the real challenge in health care" (ibid: 30). He went on: "it is only by developing decentralised non market models for public provision...that we will show to those who assert that whatever the market failure the state failure will always be greater, that a publicly funded and provided service can deliver efficiency, equity and be responsive to the consumer".

If a week is a long time in politics, then five years must surely be an eternity. Over this period, Brown appears to have be been seduced by the pro-market enthusiasts circling the government. In his first major speech on the National Health Service (NHS) as prime minister, in early 2008, he firmly endorsed the direction for NHS reform set by his predecessor, Tony Blair (Brown, 2008). The speech is peppered with references to the importance of competition, choice and diversity of supply in improving health and health care. Indeed, with strong echoes of the health voucher proposal under the last Conservative government led by Margaret Thatcher, he wanted reform to go further advocating individual budgets for patients, initially those with long term conditions. Indeed, such a development featured in the final report of the NHS next stage review announced in mid-2008 by former junior minister, Lord Darzi (Department of

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Health, 2008). A number of pilot schemes will be launched and evaluated in 2009. Direct payments, as Le Grand argues in his book, are claimed to bring a range of benefits, including empowering patients and improving their health through increasing their range of choice of provider and/or treatment. But, as with choice and competition more generally, there is concern that major issues of principle have yet to be properly thought through. It may be that individual budgets could weaken the NHS and the universal principle on which it is predicated. How is the circle to be squared between a service still largely free at the point of use with a model of cash payments? What will be included as part of people's individual health budget, and what will continue to be part of their core NHS entitlement? What will stop the latter being eroded as governments and economic circumstances change which, in the case of the latter, have done so dramatically and rapidly?

It is often claimed by proponents of choice and competition that they are not synonymous with the privatisation of health care. But they are being disingenuous and their protestations fly in the face of evidence to the contrary. While in theory they may be correct, in practice there is ample evidence that developing a market in health care will involve for-profit companies. Indeed, the UK government has encouraged a diversity of providers, both for-profit and not-for-profit, in running a range of services including independent sector treatment centres and primary care services. In some cases, these companies are testing the water and running services as loss leaders. But once a toehold has been established, it is likely that they will aggressively expand their operations and begin to put upward pressure on costs. That is how health care markets work and to suggest otherwise is either being recklessly naïve or disingenuous. It is what infuriates and frustrates those opposed to such developments. Evans put his finger on it when he pointed to the specious justifications that have survived "frequent logical or empirical refutation" (Evans, 2005). He goes further, concluding that the beneficiaries of what he calls "privilege-preserving" funding arrangements "are intellectual 'zombies', constantly brought back to life by those whose interests they promote" (ibid: 286). And he asserts that these fundamental conflicts of interest "cannot be resolved by 'fact and argument'. These conflicts may go into remission, but they never disappear".

In his classic analysis of health care politics, Alford adopts a similar stance characterising health system reformers as falling into one of two camps: "market reformers", who hold state involvement in health care and bureaucratic complexity responsible for the ills apparent in health care systems, and "bureaucratic reformers", who claim that the defects are all the fault of those who subscribe to markets and competition which obstruct the orderly planned provision of effective health are and have no place in medicine (Alford, 1975). Like a swinging pendulum, health policy oscillates between the two camps.

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### *Evidence-based policy or policy-based evidence?*

Possibly the most surprising aspect of the ongoing debate over markets and medicine is the absence of convincing, or unequivocal, evidence in their favour. As noted at the outset, it is one thing subscribing to an economics textbook view of markets and how they operate and quite another to examine the dynamics of competition and markets in the real and messy world of politics. Indeed, Le Grand seems to be aware of this disjunction although fails to confront convincingly the issues at stake. Throughout his book, he makes much of the need for good policy design with appropriate incentives in place. The Devil, as he rightly claims, is in the detail. But surely this is the nub of the issue. Perfect policy and perfect implementation are illusions. Getting the conditions and detail right is precisely what governments are notoriously bad at doing. They certainly do not exist now, as the Cabinet Office's capability review of the Department of Health has made abundantly clear (Cabinet Office, 2007). It is a damning indictment of a major government department that is criticised for lacking leadership and strategic coherence. Le Grand's defence of the government's health strategy and rather feeble attempt to make it appear coherent and logical sounds distinctly hollow when set against such counter-evidence. More persuasive is the assessment offered by Kettl in his study of public governance and private markets. "Despite the enthusiasm for entrepreneurial government and privatisation, the most egregious tales of waste, fraud, and abuse in government programs have often involved greedy, corrupt, and often criminal activity by the government's private partners – and *weak government management to detect and correct these problems*" (Kettl, 1993: 5, emphasis added).

As Evans never tires of repeating, to avoid markets generating inequities in access and other flaws requires a strong and sophisticated regulatory environment. Yet, as he graphically puts it: "Structuring such an environment is like riding north on a southbound horse" (Evans, 2005). Powerful incentives exist for participants to circumvent regulatory controls and move in the natural direction – natural, that is, for them.

There is a paradox here. Government's growing reliance on the private sector is weakening its capacity to manage public–private partnerships since the expertise required has been lost at precisely the time it is most needed. Instead, there is increased reliance on contracted out expertise and specialist knowledge over which governments exercise little control. It is a weakness compounded by the very nature of public service activity where the goals being pursued are invariably complex, conflicting and political in origin, and which have constantly to be renegotiated. The consequence is that it becomes all but impossible, effectively, to regulate the new marketplace that has been created, which begins to take on a life of its own. To return to Evans, once the genie is out of the bottle it cannot be put back in. Markets do not automatically self-regulate, as has become glaringly evident from the contribution of the financial

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sector to the economic recession, and to assume otherwise is naïve, if not irresponsible, in the extreme.

At issue here is why functions end up in the public sector in the first place. Invariably they do so for good reason, although it is a fact conveniently overlooked by proponents of choice and competition who see no significant distinction between public and private organisations, and regard them as outmoded ideological constructs. Indeed, and somewhat ironically, given recent policy announcements, a principal reason lies in the negative consequences of a surfeit of choice and competition and what, in respect of the state of health services in the UK prior to the setting up of the NHS, became an intolerable degree of inequity (Mohan, 2002).

A powerful critique of markets forces in health care is offered by Woolhandler and Himmelstein (2007). It is intended as a warning cry to those policymakers and advisers in Europe who favour the introduction of choice and competition into a publicly funded healthcare system. They urge them to think again and not go down the US route, claiming that US health care is a perfect example of market failure that has increased administration costs without any gain in productivity or efficiency. They conclude: "evidence from the US is remarkably consistent: public funding of private care yields poor results". Market mechanisms are therefore to be avoided since "only a dunce could believe that market based reform will improve efficiency or effectiveness. Why do politicians persist on this track?" It is a question that might also be directed to their advisers who have had an instrumental, if only dimly perceived, role in shaping the reform agenda. Whereas politicians are ultimately accountable, the same is not true of unelected and unaccountable advisers whose power and influence has grown markedly over the past decade or so.

It may be that the US experience will be repeated in the UK. The market remains in its infancy and it is still early days but from a stocktake of the NHS reforms by two respected independent watchdogs which focused on those developments most closely linked to the introduction of greater choice and competition, the conclusion was that the changes resulting from the market-style changes "are not striking" (Audit Commission and Healthcare Commission, 2008: 69). Indeed, the progress report concludes that health economies that had implemented the reforms "were not performing at a significantly higher rate than those that had limited reform levers in place" (ibid: 71). Moreover, where performance was high it could be tracked back to the fact that such organisations had performed well historically.

On the issue of choice, the evidence is also similarly contested. The case for choice increasing equity is made by Le Grand on the grounds that collectivist provision has favoured the middle classes skilled at negotiating their way around complex services and failed the poor and inarticulate. But the problem with the shift to choice as a means of tackling inequity is that it makes many assumptions about both the causes of inequity and the optimal policy response

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to tackling them. Critics of the choice leading to improved equity argument claim that encouraging explicit choice "might further empower those with greater voice" (Barr *et al.*, 2008: 273). Yet, often the only evidence ever cited by the advocates of choice for the poor and deprived is the London Patient Choice Pilot (LPCP], which showed that the uptake of choice was the same across primary care trusts of varying levels of deprivation. Such a conclusion is not supported by other evidence, notably an extensive scoping review of choice conducted by Fotaki *et al.* (2006). Commenting on the LPCP evaluation, the researchers note that several disadvantaged groups were excluded from participation in the study, which suggests that its findings should be treated with caution. A second, earlier review of choice conducted for the Social Market Foundation similarly concluded that there was a lack of definitive evidence to indicate the extent to which socio-economic factors influence the take up of choice (Williams and Rossiter, 2004). Such findings lead Fotaki and her colleagues to conclude that "the impact of choice on equity is consistently negative... Providing more choice increases inequity. This is partly because the better off are more able to exercise choice when it is offered... At the very least, choice policies have the potential to increase inequity." The response to such evidence, where it is even acknowledged, is to allay the fears of the doubters by proposing patient advocacy schemes or suchlike, whereby patients from deprived groups can receive advice and be helped to make an informed choice.

If the findings on choice increasing inequity are sound, then it demolishes one of the central pillars of Le Grand's case for choice. More recent evidence from the stocktake of the progress of the NHS reforms confirms some of the difficulties in offering choice (Audit Commission and Healthcare Commission, 2008). In keeping with other studies, it found that patients unanimously wanted a high-quality, local hospital that they could access. But "there was not a universal view that the choice policy would achieve this aim" (ibid: 45). Furthermore, the watchdogs "found no evidence that the choice policy was resulting in significant changes for the patient or to patient pathways" (ibid).

There are many other myths surrounding the virtues of choice and markets. One is that markets will offer a more tempting array of choices than could possibly be provided by other arrangements. But simply offering more choices is beside the point if the choices are deemed unattractive or are not what is needed. For critics of markets in health care, effective reform of health systems "will require constraining the market, not relying on it" (White, 2007: 20).

If the evidence concerning the alleged virtues of choice and competition is so equivocal, why do policy-makers persist with a set of reforms which threaten the very values and principles they profess to uphold? At the very least, perhaps they should proceed more cautiously and on the basis of properly designed and evaluated pilots or experiments. But governments generally dislike making policy in such a way and are rarely prepared to wait for the evidence to become available, even in those cases where it is sought. More likely, they have already

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made their minds up irrespective of the evidence, at best making selective use of it, thereby reaffirming the view that rather than striving for evidence-based policy, what we have in practice is policy-based evidence. But the appeal of markets may also be reinforced by two other factors. First, there is the world-view offered by Bobbitt in his epic study of war, peace and the course of history (Bobbitt, 2003). According to his thesis, the nation state is being replaced by the market state and this is happening because the nation state is unable to adapt to rapidly changing circumstances. Globalisation is therefore a key driver of current policies favouring choice and competition, as it has undermined the collectivist values represented by the nation state and focused instead on the benefit of individuals. The second driver may be rather more prosaic although not unrelated. In his discourse on trust in politics and politicians, the sociologist, Richard Sennett, suggests that the New Labour government acting as a consumer of policy has done much to erode public trust in both the policies and in politicians (Sennett, 2006). He puts this restlessness and endless stream of policies down to a consumption mentality that is also evident in business where short-term thinking prevails. In short, the government has fallen victim to one side effect of the very globalisation policies it espouses.

But there is nothing inevitable or preordained about the policy thrust with its fixation on choice and competition. There is an alternative paradigm and it rests largely with working with what already exists (or, perhaps more accurately, did exist).

## Another way: rediscovering public service

As choice and competition become established in the NHS as the government intends, despite public opinion being highly sceptical of such developments (Needham, 2008), it seems likely that the health care market will come to resemble a traditional market. But this is to miss the point of why the NHS is a public service and why it was set up in the first place over 60 years ago. ''Treating public services as though they are simply transactions misses many aspects of what makes them public'' (Clarke *et al.*, 2008).

Not all economists are of a single mind when it comes to the lure of markets or market-style incentives. While Le Grand clearly supports their introduction to improve performance among health care providers, fellow economist, Peter Smith, disagrees and does not support even modest experimentation with stronger market incentives, drawing attention to the adverse effects that market incentives can produce in health care. He suggests that market disciplines could seriously undermine the professional ethic in health, resulting in poorer quality care and health outcomes for patients (Smith, 2003). The professional ethic might be crucial because, as Smith points out, contracts can never be complete. Professional norms therefore play a critical role in smoothing out the inevitable

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imperfections in market contracts. It is an important and under-researched issue that merits further attention. Whereas economists tend to focus on information and incentives as the principal instruments to achieve improved performance, a third determinant of behaviour, long recognised by sociologists and other social scientists, centres on the intrinsic objectives of personnel. Professional culture, as others have also noted [see, for example, Degeling *et al.* (1998)], is an important determinant of improved performance. It is hard to see how a competitive market will contribute to a more effective professional culture. Indeed, it may well corrode such a culture and encourage the development of competitive behaviours that are counter-productive and militate against better care and outcomes. For Smith, the emphasis should be on "designing appropriate incentives into terms of employment, and nurturing a professional culture of sharing experience and seeking out continuous improvement" (Smith, 2003: 31). He concludes: "true market competition introduces a set of very raw incentives that carry serious potential for adverse outcome for many aspects of health care".

But market incentives have other drawbacks and introduce other distortions. For instance, creating a market in secondary care, as the policy of foundation hospitals combined with patients exercising choice does, focuses attention on the acute sector and on hospitals at a time, perversely, when the policy emphasis is on care out of hospital and on health prevention. Where is the joined up policy here? Yet, as Smith argues, it is difficult to envisage circumstances in which a truly competitive market can be created for many common chronic conditions with complex patient needs for which there are few, if any, clear measures of outcome, and where the need is for a heavy reliance on joined-up working with other agencies, notably local authorities. Competitive markets could well work against the development of effective partnerships and result in greater fragmentation of care. It is another example of the policy incoherence that lies at the heart of the reform strategy, no matter how earnestly defenders of the government's policy pretend, or wish, it were otherwise. Similar arguments apply to public health, where issues of choice and competition seem irrelevant especially when it comes to tackling the social and structural determinants of health that require a whole system perspective and effective collaboration across a range of partners. However, not all agree – see former health adviser, Paul Corrigan's, spirited defence of choice in public health (Corrigan, 2007).

As has been observed, "market incentives and behaviours by themselves do nothing to solve basic organisational problems such as how to manage complex organizations filled with professionals who have conflicting values and interests" (White, 2007: 18).

In exploring an alternative to markets, there is a prior need to acknowledge "the essential rationale of public service" and draw a distinction between the public service orientation and consumerism, which is the hallmark of markets (Clarke and Stewart, 1988). Hankering after market solutions omits any

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mention of why public health systems developed in the first place. Services like health have been placed in the public sector precisely because they are different from those in the private sector and demand to be run as such. In particular, considerations determined by the political process rather than considerations of the market place are critical. The management and delivery of services "has to be grounded in the distinctive purposes of the public domain which political theory would suggest involve democracy, community, citizenship, equity, and discourse" (Stewart, 1998: 23).

Addressing doctors in New Zealand, Powell captured the policy conundrum when he observed: "If the objective is to produce a universally available and comprehensive public good then an integrated and co-ordinated system is necessary rather than a reliance on a system more orientated towards niche markets and profits. It requires a high level of public funding and benefits from a high level of public provision. Private systems cannot do this because it is not their reason for being" (Powell, 2006: 9).

Together with such an approach is the need for better management and a different approach to harnessing professionals to policy goals. A systemic problem with the NHS has not been the absence of choice and competition, which have become a cruel distraction, but poor leadership and management – for the most part, activities that clinicians have too often sneered at instead of actively engaging with them. What is needed is a modified conception of public service to fit it for the challenges of the twenty-first century. Such a conception would embrace notions of public participation through citizenship and a refreshed conception of professionalism, best described as 'responsible autonomy' (Degeling *et al.*, 2004).

Such notions come together in the concept of co-production. This combines the respective strengths of the public and professions. There is no place in co-production for outmoded notions of professional dominance or paternalism. As Tudor Hart puts it, "recognition of patients as co-producers rather than consumers would begin to solve several problems which are otherwise likely to get worse" (Hart, 1994: 43). For him, the model of co-production is "a different, socialist way to look at health production in the NHS, as neither a state funded autonomous medical hierarchy nor a market of competing corporations dominated by business-trained executives". In the co-productive model front-line staff "have a distinctive voice and expertise as a result of regular interaction with users" (Needham, 2008: 222). They are not regarded as 'technical monkeys' delivering to target and following guidelines, but use judgement and tacit knowledge in reaching decisions. They are acting as craftsmen (Sennett, 2008). Collective co-production refers to programmes and interventions that benefit whole communities. It is seen as more beneficial than individualistic forms. The appeal of co-productive approaches lies in their potential to bridge the polarities in public service debate, although we need to understand them more fully before embracing them too enthusiastically. Nonetheless, it is suggested

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that they may offer a more promising way forward than choice and competition, without threatening to 'hollow out' the NHS and corroding its values and social purpose. The production of an NHS Constitution, also heralded in the Darzi next stage review, is designed to ward off such threats and protect its founding principles but it remains unclear how far it will succeed in erecting such a firewall and preventing it from being breached (Department of Health, 2009). As Mohan warns, "the introduction of the remedies of competition, markets and private enterprise may be fatal to the ideals of the NHS" (Mohan, 2009).

## Conclusion

The founding father of the UK's NHS, Aneuran Bevan, wrote in 1952 that the NHS represented "...a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst" (Bevan, 1952). Yet, the direction of health policy, enthusiastically embraced by Le Grand, and so ably articulated in his book, among others seems intent on introducing, or perhaps more accurately, reintroducing, those very same commercial principles spurred on by a 'progressive' myth that society has changed irreversibly and that there is no other way. There is another way, but only if policy-makers get their advice and guidance from those who share Webster's view that it is "entirely misleading to caricature Bevan's health service as some kind of obsolete soviet-style command and control system" (Webster, 2002). It is a comment that merits careful reflection in the NHS's 61st year.

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