EQUALITY, EQUITY AND CHOICE

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THE EQUALITY EXCHANGE THINK PIECES
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Some months ago, I finished my work as an independent reviewer for the UK government. I had never done such a thing before, but they needed someone from outside government to look dispassionately at the way people were using their choices in public services – and decide what barriers were there to prevent them.¹

I organised and participated in a dizzying number of round tables to find out, and must have spoken to well over 100 service users face to face, and almost as many professionals, but one in particular stands out. She had muscular dystrophy and had to see her consultant every six months, which meant a two-hour round trip plus half an hour or more in the waiting room. It meant going over a large river and paying a toll, and all she says when the doctor asks her how she is – is ’I’m fine’. What she really wants is to check in occasionally by phone, and see him when she’s not fine. But she can’t because his slots are full seeing people who are also fine.

What struck me about her was that she was asking for something quite simple, though important to her as a long-term patient. It was a choice about her treatment, in a sense, but not one that is recognised currently by the system in the UK. I was particularly interested because it seemed to imply a broadening of the limits of choice, and in a way that might possibly address the conflict between choice and equality.

**CHOICE AND EQUALITY**

When the idea of public-service choice emerged in the US public-school system, it was envisaged as a lever to enforce quality. It allowed poor, excluded families to send their children to the best schools when the inner-city ghettos had tended to trap them in the worst ones. When school choice was introduced into the UK in 1994, it had a similar intention.

But in practice, the choice agenda in the UK has had a much more narrow focus, mainly on managed competition between providers. This has been designed to raise standards, and there is some evidence that it has. But it has been politically controversial because of fears that choice would inevitably benefit those who are articulate and demanding enough to use it.

The Nordic experience of choice is that it has been organised in a range of different ways, but with a heavy dose of local democratic control, rather than the central control of the UK systems, and with a rather different approach to equality – the Nordic approach has tended to emphasise equality of outcomes; the UK approach to emphasise equality of access.²

But the real difference is in the underlying equality of the people using services. Choice is more controversial in the UK because of the possibility that it might exacerbate inequality; in the more egalitarian Nordic countries, this is less of a consideration.

The poll that I commissioned as part of the review is pretty clear about this. It shows overwhelming political support for the idea of choice, but also that around a third of the population have difficulty with it – either because they lack the confidence or the access to the written information they need, or because they lack the necessary transport.³ In other words, there is a problem about choice and equality in practice. There is a tendency for more articulate people to get more benefits because of choosing differently.

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But even among the most articulate, there turned out to be a confusion about what choice means in practice.

I met one long-term patient in Leeds who said she would have ‘moved to another country’ if she could have escaped the consultant who she felt had been rude and dismissive to her. This is not currently a choice that she is given by the NHS, but – if she is articulate – she can usually manage it by calling it a ‘second opinion’.

The difficulty is that choice and competition, although UK policy makers often use the terms interchangeably, are not the same. As service users know very well, there are times when choice and competition are aligned, but there are also times when they cancel each other out. This is when, for example, the choice is made not by patients but by service commissioners choosing between two alternative candidates for block contracts. Or when the weight of demand is such – as it is for some popular schools or GP surgeries – that the choice is made by the institution, not by the user. In both cases, there is competition, but no user choice.

This is a long-term problem for the choice agenda in the UK. It means that choice is politically unstable. It is controversial because it appears to have a hidden agenda (competition) and an unspoken by-product (inequality) that makes it appear vulnerable to a change of political leadership just as it is vulnerable to professionals who disapprove of or misunderstand it. In social care, the vast majority of professionals have bought into the agenda of control and personalisation, although there are disagreements about how this is best promoted. In other areas of public service, choice is sometimes seriously contested.

This dilemma, and the need for a system of choice that can genuinely tackle inequality, has made me wonder how it might be possible to broaden the choice agenda – so that it is not limited to competition between providers and the relatively narrow choice between them. The new emphasis would be not so much on choosing between regulated options, but making services flexible enough to suit individuals better – closer to the personalisation agenda in social care, where service users get budgets they can (theoretically, at least) use in ways they believe are best suited to their needs.

HOW FLEXIBILITY MIGHT BE ACHIEVED

The most obvious difference between flexibility and competition is that it does not require a detailed regulatory infrastructure in quite the same way; it requires general guidance about how flexibility can best be achieved, but not the kind of competition regulators, like Monitor, that are controversial in the UK system. Experience with personal budgets in social care suggests that risk-averse local administrators can frustrate the broad aims at local level. It also suggests that central regulations are not enough to guarantee personalisation locally. It suggests that the best approach would be to find ways to strengthen the confidence of service users to ask for something different, and perhaps provide duties on service providers to consider this. I imagine this would be like a ‘right to request’ flexible service delivery. In each case, the provider would not be obliged to provide flexibility if it is impossible, but they would be obliged to explain why and that letter should be posted on their website. This would be aimed particularly at situations where systems or bureaucratic arrangements get in the way of what people need. For example, if they want the choice of a consultant who won’t mind them asking lots of questions, or to study Spanish at A Level when all that prevents them is their school’s timetabling system, or to go to bed later than 17:00 when their carer comes round.

These are basic flexibilities in the system that articulate people can often get now by being assertive, but which others can’t.

4. One recent study found that fewer than half of personal budget holders (37–46 per cent) felt that their council had made it ‘easy’ or ‘very easy’ for them to change their support, choose the best service options, voice their opinions or complain. Between 13 and 24 per cent felt that councils had made it ‘difficult’ or ‘very difficult’ to do these things. See C. Wood (2010), Personal Best: Demos, London.
Nothing along those lines exist in the UK system at the moment but it says above they do if they’re articulate, but flexibility would build on the experience of a number of local innovations which tackle parts of the basic inflexibility problem. These include:

1. **SCALING BACK THE SEPARATE SYSTEMS AND PATHWAYS THAT TRY TO APPLY POLICY TO DIFFERENT CATEGORIES OF PEOPLE**

This is extremely difficult to do if contracts are awarded separately. One alternative way forward is suggested by the success of Grimsby-based Care Plus, a co-operative social enterprise owned by its 750 staff, with attached charities (Care4all), which is able to integrate a wide range of community health and social care services under one roof. It has also been experimenting with personal budgets in health, and it has a rule that if anyone phones asking for information, they will be given the information, and not be passed on elsewhere.5

The challenge here is how you achieve a personalised service as the organisation grows, and it remains to be seen whether this will be successful. Care Plus only began in 2011, but it is owned by its staff and the mutual approach provides some safeguards for the shift out of NHS employment – and could provide a new freedom for frontline staff to shape services to suit people differently, where that is needed.

2. **GIVING MORE POWER AND RESPONSIBILITY TO SERVICE USERS**

One way forward has been made possible by the Cambridge-based technology company Patients Know Best (PKB), which has developed a system whereby the patients own their own data, and can provide or withdraw access to professionals. This avoids the inflexibilities of asking permission to share data between professionals, and makes it easier for online consultations, where appropriate. The system is used for patients with intestinal failure at Great Ormond Street Hospital in London and St Mark’s in Maidenhead.6

The difficulty here is that doctors are often suspicious of patients owning data, and simply asking them to take part in the system is usually not enough. PKB has solved this problem by persuading whole networks around particular complex conditions to switch, or more recently whole health regions.

3. **ENCOURAGING A RANGE OF DIVERSE SMALL CARE PROVIDERS**

Flexibility requires a diversity of providers, and Nottinghamshire County Council has developed a way of encouraging the development of micro-providers in social care, together with the charity Community Catalysts. They have started 49 in the last two years, and these are mainly social enterprises.7 In this respect, the blurring of distinctions between public, private and voluntary sectors helps the development of flexibility.

The main barrier here has been the inflexibility of the way many local authorities interpret the rules around personal budgets, often limiting their choice of provider to the council’s preferred supplier list. Micro-providers have tended to cluster around the most enlightened local authorities, and those which signpost a wide range of new suppliers.

4. **PROVIDING AN ADVISORY INFRASTRUCTURE THAT CAN HELP SERVICE USERS WITH BUDGETS AND TAKE THEIR SIDE**

This is most relevant to negotiating individual budgets, and the emergence of new services like My Support Broker, which trains and accredits disabled and older people to be professional peer brokers to help others like themselves to plan, find and manage their healthcare and support services.8

This is difficult in a period of shrinking budgets, as traditional local advice services have their grant funding cut. What MySupportBroker.com manages to achieve is to provide a brokerage service in return for a percentage of the total budget that its clients are awarded – and usually do so for about half what it costs to do the same job through local authorities. This means taking advantage of some of the diseconomies of scale.

5. **BLURRING THE DISTINCTION BETWEEN PROFESSIONALS AND SERVICE USERS**

There is considerable experience of users being involved in decision-making in the Nordic tradition, but the most powerful shift in the power balance can arguably take place where service users work alongside professionals to deliver services, as they do for example in the Rushey Green Time Bank in Catford, linked to a GP surgery in a suburb of south London.9 This agenda is also referred to as co-production.

The challenge for co-production is to convince the health professionals that supportive social networks are important, and that they can potentially save public services money. An even bigger challenge is to find ways to extract those savings from multiple budgets, and draw them forward to pay for the time bank – or similar – to make the savings possible in the first place.

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5. See www.careplusgroup.org.uk
6. See www.patientsknowbest.com
7. See www.communitycatalysts.co.uk
8. See www.MySupportBroker.com
9. See www.rgtb.org.uk
BARRIERS TO MORE FLEXIBLE SERVICES

There are certainly possible objections to this kind of approach. Patients may choose badly. They may fail to take responsibility for the wider system by misusing the flexibilities they are offered. More flexibility might benefit those most able to take advantage of it, and widen inequality – and there would have to be safeguards and more informal advice available for people, and institutions (like time banks, for example) that spread the benefits to hard-to-reach groups.

There may also be higher costs from treating people more individually, and the costs will come before the potential savings are available. Financial innovations that tie professionals too closely to narrow numerical outcomes, like the current experiments with ‘Payment By Results’, may also make flexibility more difficult to achieve.¹⁰

Not all of these are likely to be such intractable problems in Nordic countries, which have usually managed to avoid the centralised managerialism of UK public services. But the cost issue is important; the evidence that flexibility can cut costs is ambiguous. Personal budgets in social care is an example of flexibility in action and, although there is considerable evidence of improved satisfaction – even improved outcomes – there is little evidence in the UK so far that it can cut costs.¹¹

However, there are two pieces of evidence which suggest that flexibility could have the potential to reduce costs.

The first is the experience of the Local Area Co-ordinators (LACs) of Western Australia, now being piloted in the UK in Middlesbrough and Derby. LACs are generalists who support practical, creative and informal ways of meeting people’s aspirations and needs, increasing the control and range of choices for individuals.

They support vulnerable people, their carers and families to build a vision for a good life that is individual to them, and to build family, relationship and community networks, starting with informal solutions – and only drawing on formal care packages when these are impossible or inadequate. LACs are designed to increase the flexibility of services and provide users with much broader choices. Savings in the Middlesbrough LAC project have been estimated at between £1.80 and £3 per £1 invested.¹²

The original LAC projects in Western Australia reduced social-care costs by around a third.¹³

The second evidence comes from the work of the systems thinker John Seddon, and the techniques he has developed to look at services and iron out what he calls ‘failure demand’, the demand in the system that is the result of failures elsewhere.¹⁴ Seddon’s studies of GP practices suggested that about a fifth of their demand came from failures elsewhere in the system, caused by hospitals providing the wrong drugs on discharge or failure to see the same doctor twice, not necessarily mistakes by the practice. The ability to break the system of its tendency towards constant repeat assessments, and treat people as individuals, would help reduce some, but not all, of this demand, and the Somerset Clinical Commissioning Group has been putting this into practice.¹⁵

A more flexible system would mean fewer set systems, but more human connection. This would certainly require up-front investment, and it would mean a rigorous concentration on preventing those diseconomies of scale that cost so much in the inflexible systems. It would mean fewer organisations, more local, multi-disciplinary teams, and a shift from back-office costs to frontline costs – and organisation for the huge number of volunteers that would be required to humanise services and allow them to reach out. It would be hard to prove its costs benefits to officials wedded to the current industrial processes, so this is as much about a cultural shift – taking localism to its next stage – as it is about organisational change.

An anecdote makes the point: a doctor’s surgery has a hedge outside which is trimmed once a year in the summer, and – when it is trimmed – lots of prescription notes fall out. Patients come out of the door with a prescription they don’t really want and shove it in the hedge. They are wasted because doctors and patients are unable to communicate properly about what is needed and what is wanted. It is a symbol of the waste in the system when it is too inflexible.

¹⁰ ‘Payment by results’ is the term given by the UK government to withholding payment to contractors unless certain targets have been achieved. The same term is used in the NHS to mean what is in effect payment by procedure, which means something completely different.
¹² Peter Fletcher Associates Ltd (2011), Evaluation of Local Area Co-ordination in Middlesbrough, PFA Ltd.
¹³ R. Chadbourne (2003), A Review of Research on Local Area Coordination in Western Australia.
¹⁵ See John Seddon’s blog at http://vanguardinhealth.blogspot.co.uk/2012/05/there-is-no-efficiency-without.html
CONCLUSION

There is a wider agenda here. Nordic systems have, to some extent, managed to avoid the main pitfall of the New Public Management, which is to regard service systems as industrial and to seek out economies of scale which, in practice, are very rapidly overtaken by the diseconomies of scale – the failures that follow from the inability of the system to provide precisely the right solution to individuals. But New Public Management-style reforms are controversial in Nordic countries, and the objective of flexibility is in some ways a potential UK alternative to the inflexibility that has tended to creep into service systems on both sides of the North Sea.

Making UK systems more flexible means making them more human, providing key individuals or key workers who can make ongoing relationships possible, and a broader agenda to redesign services around what the individual users want – and making professionals free to use what solutions they feel are most appropriate.

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