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Public Service Reform and Social Inequality

Peter Taylor-Gooby

A major theme in public service reform is the empowerment of service users by giving them greater opportunities for choice between alternative providers. This raises challenges for policy-makers: during the last decades living standards have risen, markets offer a greater range of choices across most areas of life, but inequalities have also grown rapidly and look set to expand further. The range of choices available to better-off people is much broader and more attractive than that confronting the poor. Is the choice agenda compatible with social justice?

This chapter considers health and social care, education and early years provision, chosen because they are all high-profile policy areas in which governments have pursued substantial reform programmes and because they offer examples of policy changes designed to offer greater choice to service users in more or less competitive markets under governments of markedly different ideologies. There are obvious problems of adverse selection by providers and differences in the capacity of users to make effective choices. Where empowerment programmes are linked to extra resources targeted on more vulnerable groups or areas in the context of good information, a functioning market and support in decision-making, they appear to have a positive effect. However the achievements are limited, even when reformers are able to direct extra resources to the services. It is hard to make much headway in guaranteeing a full range of choices for everyone in an unequal society without embedding the programmes within an aggressively redistributive welfare state. The programme of the current government – greater choice in a context of harsh cut-backs – may indicate how far the choice agenda can advance people's interests when it is not combined with policies that mitigate unequal incomes and wealth.

Responsiveness, cost-efficiency and equality in a more unequal society

For much of the post-war period public services in the UK were delivered by the central state (cash benefits, the NHS) or local government (schools, personal social services, social housing). They were financed chiefly through centralized taxation with some local government support. The legal framework specified entitlements and access, with considerable opportunities for variations in provision in the locally administered services. Central interventions in the organization and structure of locally administered services, particularly education, became prominent from the 1960s onwards. More recently there have been moves to decentralize budgetary responsibility to provider agencies and directly to service users to advance choice and competition.

The main drivers of change (Alldritt *et al.*, 2009; Driver and Martel, 2006; Powell, 2002) have been:

- Demand by service users for greater empowerment, accountability and responsiveness, sufficiently widespread and powerful to be recognized across all the main political parties as a central feature in manifesto programmes and elsewhere (HM Government, 2009; Le Grand, 2003: 163; Conservative Party, 2010: 45);
- The need to contain pressures to increase spending, exacerbated by global competitiveness (Commission on Social Justice, 1994), declining public sector productivity (Simpson, 2007; Ayoubkhani *et al.*, 2010; Penaloza *et al.*, 2010), anticipated increases in the cost of pensions and health and social care for elderly people (HM Treasury, 2009a) and (more immediately) the cost of the 2008–10 stimulus package and banking bailout, plus extra social spending as the economy falters (HM Treasury, 2010a);
- Concerns about fairness in access, standards and the capacity for innovation in existing provision (PMSU, 2006).

Various policy innovations have followed, pursued with greater or less vigour at different times and influenced by the commitments of different governments to public spending, gathering pace from the late 1980s onwards. They may be grouped under six headings:

- Stronger Treasury control over budgets across all areas, locally and centrally administered.
- Decentralization of provision to a range of agencies (commercial

companies, NGOs and community groups, budget-holding state sector agencies), typically operating in competition.

- Intensification of monitoring, through regulation, inspection and publication of levels of achievement.
- Development of new methods of promoting innovation and setting standards, through targets, specific initiatives and programmes, and targeted payments.
- Greater involvement of service users, through choice between providing agencies, better access to information on standards, in some areas opportunities for voice.
- In relation to cash benefits, more vigorous efforts to mobilize those of working age into paid work, both through stricter limits on entitlement and measures to support bottom end wages.

These developments reflect shifts in the context in which government operates: declining deference and greater individual self-confidence leading to querulous citizens (Giddens, 1994); the move towards a more networked society as a result of the use of ICT and more diverse and globalized power structures (Stoker, 2006); the decline of traditional political structures (most importantly in a class-based labour movement) and growing diversity in life-styles, needs and demands (Jessop, 2002); and trends in government to a 'hollowing out' (Rhodes, 1997), to risk management (Hood, 2010) and to a New Public Management (Flynn, 2005). The UK is often seen as unusually centralized in government structures but at the forefront of the above trends so that the pressures for change are particularly acute (Esping-Andersen, 1999). The 1997–2010 government focused on control, monitoring and standards, while the 2010 coalition has emphasized spending cuts, decentralization, user control and privatization.

The reform programmes have been extensively discussed (for example, Le Grand, 2003, 2008). In relation to inequality the main debates concern conflicts between empowerment and equality. Middle-class service users are often seen as more successful in gaining access to services. Their greater resources allow them to seek out the best providers and their cultural capital makes them both more attractive and more able to press home their demands (Titmuss, 1958). The risk is that user empowerment allows these differences full play.

Issues of equality have become more prominent as the 1997 New Labour Government focused attention on poverty and social exclusion (Mandelson, 1997; NPI, 2010; Equalities Review, 2007). Analyses of the dispersion of market

incomes in the UK show a substantial increase in the share received by lower income groups during the 1970s, followed by a sharp decline in the 1980s. The relative shares of those on higher incomes grew during the 1980s and more slowly in the 1990s. For those at the very top the increase has continued into the twenty-first century and probably still does, while inequalities appear to have roughly stabilized for most of distribution (Atkinson, 2007: 49; Hills *et al.*, 2009: 24). Wealth appears even more highly concentrated at the top (NEP, 2010: 12).

The move by the UK from a European to more US pattern of income distribution is attributed to a number of factors including the impact of changes in labour process, more intense competition and greater flexibility in relation to and changes in household structure (Freeman, 1995; Bardhan *et al.*, 2006). Attempts to understand the relative importance of these changes indicate that access to employment has been the most important factor followed by household structure (Brewer *et al.*, 2009: Table 24). This reflects the relative success of the 1997 Labour Government's policies in containing poverty among families with children and in supplementing incomes among lower income pensions (Hills *et al.*, 2009: 44). In addition the gradual and slowing trend to a decline in the gender earnings gap (McKnight, in Hills *et al.*, 2009: Figure 5.13) has reduced inequality (Brewer *et al.*, 2009: 76).

Future trends are uncertain. There is no indication that returns at the top end will fall in more competitive and globalized markets. In the immediate future, higher unemployment will increase bottom-end inequality. The trend to reduction in poverty among families without access to employment came to an end in 2004–5 (Sefton *et al.* in Hills *et al.*, 2009: 44). The 2010 government has cut the benefits available to those of working age and particularly housing benefits sharply, is cutting entitlement to benefits for disabled people by more than half and is introducing more stringent eligibility rules for single benefits, unemployed people, students and others, and is raising the pension age (Taylor-Gooby and Stoker, 2011). The impact of proposed pension reforms, designed to simplify state provision by providing a single flat-rate scheme is unclear, since the level of benefit has not yet been finalized. The decline of occupational pensions may reduce one source of inequality for this group (Evandrou and Falkingham in Hills *et al.*, 2009: 176). The overall picture is one of greater inequality between working and workless and higher and lower-paid households. Calculations by the Institute for Fiscal Studies indicate that the cuts package of the 2010 government bears just over twice as harshly on the lowest income tenth of the distribution as on the top half (Browne, 2010).

The long-term emphasis on the empowerment of consumers, cost-efficiency and fair access alongside a 'fanning out' of market inequalities, mitigated chiefly by targeted benefit policies, raises issues for public service reform. Middle-class groups have always done relatively well out of the welfare state. Public service reforms that give greater power to private sector providers and to service users risk exacerbating the inequality between advantaged and more vulnerable groups.

Directions in reform

The objectives outlined above have been pursued through a range of methods.

The main directions in recent reform and the logic that underlies them are well summarized in a recent Prime Ministers Strategy Unit (PMSU) paper (2006) and taken much further in the current Localism Bill and Open Public Services White Paper (Cabinet Office, 2011). This emphasizes four approaches:

- Top down performance management (targets, regulation, inspection and where necessary intervention).
- Users shaping the services from below (greater choice between providing agencies, funding following the user, more opportunities to exercise voice).
- Market incentives to promote efficiency and quality (through competition, contestability or bench-marking against other providers and commissioning).
- Improving capability (better leadership, developing the workforce and improving organizational co-operation).

The current government is placing reliance particularly on the second and third aspects of the new responsive policy-making.

Examples of the first kind of policy are the 1997–2010 government's Comprehensive Spending Review Targets for waiting lists, morbidity and inequalities in health, and targets for Key Stage test outcomes in education; the National Institute for Health and Clinical Excellence (NICE) evidence-based regulation of drugs and guidelines on treatment and the National Curriculum guidelines; inspection by Monitor or Ofsted agencies and the Cancer Strategy and literacy and numeracy hours.

For the second, the Patient Choice and Open Enrolment programmes, fund-holding by general practitioners (GPs) and primary care trusts (PCTs) and Age-Weighted Pupil Units, the Link and its successor schemes and the

move towards a greater role for parents and, through the Academy, Trust and Faith Schools programmes, business, religious groups and non-governmental organizations (NGOs) in school governance. Co-payment, typically through partial state contribution for a paid-for service is rare in the NHS and statutory age education, but is a feature of academies and in means testing for social care support, in the attendance allowance and more recently in direct payments for personal care, which may be privately supplemented, in student finance subsidies and in the contribution of tax credit to child care costs.

Market incentives are extensively discussed (for example, Le Grand, 2008) as a central feature of New Public Management, for example through competition between various NHS Trusts and Independent Diagnosis and Treatment Centres, through the impact of choice of school, enhanced by a greater range of specialist and faith schools and academies, and through Compulsory Competitive Tendering and Best Value in local government. The localism agenda of the 2010 government and the determination to extend the role of private for-profit service delivery across social housing, the employment service, within the NHS and across all local government services appear certain to expand the role of the non-state provision vastly.

Capability improvements include measures to enhance training (the NHS and Schools leadership colleges), improvements to pay and aspirations about status in health care, education and (to a lesser extent) social services to enhance recruitment and retention, and more emphasis on networking between professionals and agencies, for example in the National Cancer Strategy and in sharing expertise and resources between schools. These initiatives appear likely to be choked off by the cuts following the 2007–9 recession.

The reform programme has been sustained by substantial increases in spending, particularly in health and social care (from 5.3 to 7.9 per cent of GDP between 19978 and 2008–9) and education (4.5 to 5.8 per cent, HM Treasury 2009b: Table 4.4). More recent policy discussion (for example, Cabinet Office, 2008) places greater stress on fairness and less on top-down performance management. The number of targets in Comprehensive Spending Review has been sharply reduced and there is more attention to direct citizen empowerment. Market-centred rather than democratizing aspects of empowerment predominate: choice trumps voice (Pierre, 2009; Le Grand, 2008). This conflicts with calls for a new localism (Alldritt, 2009; Mulgan, 2003) and for democratic reform (Stoker, 2006; Lister, 2003). Since 2009, reform has taken place in a climate of spending constraint. The 2010 government is implementing the harshest spending cuts since the 1920s (HM Treasury, 2010b), so

that privatization, localism and user empowerment are set in a landscape of declining public provision.

Implications for inequality

The reforms cover a broad range of activities. The services involved account for more than a fifth of national product and touch the lives of the vast majority of citizens to a greater or lesser extent. The above discussion indicates continuity in trends with an enormous variety of policies and reforms reflecting the general themes of responsiveness, cost-efficiency and fair access.

Consideration of the impact of reform on inequality is hampered by difficulties in disentangling evidence of change along a number of dimensions and in establishing a causal link between particular aspects of the new policies and changes in outcomes. The problems are exacerbated by the fact that policies operate in the context of entrenched assumptions, working practices and patterns of behaviour, for example in changing relationships among professional staff or in raising aspirations about available career paths among young people, so that their impact can only be realistically assessed in longer-term reviews. We will review developments in education, health care, early learning and individual budgeting in social care. These areas are chosen because they differ along three related dimensions that are prominent in debates about reform: provider control over access, transparency of need and user control over budgets.

In health care professional control over decisions about the need for treatment and their capacity to influence how and where it is provided are seen as crucial to inequalities of outcome (Klein, 2006). In education, the over-subscription of more attractive schools allows providers to exercise a bias towards students who are more attractive to teach, often the middle class (Ball, 2008). In early years provision and social care, however, there is substantial informal provision with a growing range of alternative providers, enabling (*prima facie*) a wider range of user choice. Reforms in health care give budgetary control to professionals in PCTs to commission much treatment, although patient choice in non-urgent services increasingly influences allocation. Planned (though contested) moves to allow GPs control over 80 per cent of NHS budgets and to expand user control through personalized health budgets take these policies further.

Open enrolment in education with cash following the student is effectively a voucher system whose application is limited by the availability of places in

sought after schools, as in the allocation of the childcare component of tax credit. The shift to academy status for most schools signals a further reduction in the capacity of local government to influence outcomes. Individual budgeting supported by personal advice in social care gives the user immediate choice in directing the use of such resources as are available.

Health care

A substantial body of evidence (Townsend *et al.*, 1972; Drever and Whitehead, 1997; Marmot, 2010) has demonstrated that, while the long-term trends in health and longevity are positive, inequalities between social groups in life expectancy, infant and child mortality and in other areas is widening (see Sassi in Hills *et al.*, 2009: 135). For example, life expectancy at birth increased by 5 per cent for women from social class 1 between 1972 and 1996, but only 3 per cent for those from class 5. For men the gap is between a 6 per cent and a 4 per cent increase.

Marmot shows that this remains true whether social differences are measured between regions, by poverty, by level of education or by the deprivation of the area in which people live (Marmot 2010: Figures 2, 3, 7, 10).

The 1997–2010 UK government policies included an increase in spending overall on health care and a substantial number of targets imposed in Comprehensive Spending Review, including waiting lists and waiting times and death rates from cardiovascular disease and cancer. The main strategies to address social inequalities were area-based, initially through Health Action Zones. This later developed into the identification of the fifth of local authorities and primary care trusts with highest social deprivation and lowest performance on health indicators as ‘spearhead’ authorities, with extra resources, specific targets and careful monitoring. This strategy has limitations since the majority of deprived people do not live in deprived areas, but has advantages in terms of practicalities in targeting, managing a viable policy through existing institutions and in testing reform programmes.

The overall strategy succeeded in relation to a number of targets: the objective of ending waiting times longer than three months for outpatients was effectively achieved by the end of 2005. For inpatients, waiting times for almost all cases fell below six months by early 2006. Overall mortality from heart disease, stroke and related illness had fallen from 141 per 100,000 (under 75) in 1995–7 to 75 by 2006–8 and from cancers also from 141 to 114 over the same period. Targets for reducing the maximum wait in accident and emergency to four hours,

ensuring access to a GP within 48 hours and choice in booking targets have also all been met (Propper *et al.*, 2008). Smoking, teenage conceptions and deaths from suicide (which in fact initially rose) have fallen but not at the rate required to meet the target (HM Treasury, 2007; DoH, 2009).

These developments are in general positive, although improvements in health outcomes follow on from established trends so it is difficult to demonstrate how far they are due to specific policies (Hills and Stewart, 2005: 333; King's Fund, 2007: 4–5). However, progress in relation to inequality targets is partial. The inequality gap between the spearhead areas and the population as a whole had fallen from 37 to 23 per cent for heart disease and strokes and from 21 to 18.6 per cent for cancer between 1995–7 and 2006–8, actually achieving the 2010 target, despite a slight increase in the last year in the latter figure (DoH, 2009: 51–52). However, the gap in infant mortality between the lowest socio-economic groups and the rest of the population has widened, as has the gap in life expectancy between spearhead areas and the rest of England (DoH, 2006). The gap increased by 7 per cent for men and 14 per cent for women between 1995–7 and 2006–8 (DoH, 2009: 14). Sassi also examines trends in life expectancy across all local authorities and shows that the trend to greater inequality by socio-economic group may have stabilized and actually be narrowing towards the end of the period (in Hills *et al.*, 2009: Figure 7.4). He uses a different data source, the Health Survey for England, to show that class gaps for self-reported poor health, cardio-vascular disease and poor psycho-social health appear to be widening between the early 1990s and 2005 (2009: 145–9).

The overall picture in relation to inequalities is 'disappointing' (Sassi in Hills *et al.*, 2009: 155) while real achievements in health care for the population as a whole must be acknowledged. However, given the negative trend in relation to inequalities for the previous three decades, modest and partial improvements may be judged less harshly. Current policies involve large cuts in capital budgets (18 per cent, IFS 2011: Figure 6.5) and level current spending in cash terms. This implies a real cut of at least 4 per cent a year in real terms, greater than any spending reduction ever achieved in the NHS since its inception. The new policies also plan to decentralize much of budgetary control to GPs and to advance personal budgets. These measures are likely to weaken attempts to advance equality, although the outcome measures to test this are not yet available.

Health care reforms in recent years have involved the use of budgetary decentralization, including private for-profit and not-for-profit Intermediate Diagnosis and Treatment Centres, targets and monitoring in the context of

extra resources. The main policies directed at achieving greater responsiveness were market and choice centred, to do with the patient's right to choose between a range of clinics and trusts for non-urgent treatment. There has been some attention to engagement through Patient and Public Involvement, Local Involvement Networks and other schemes and the inclusion of lay members in trusts although there is no evidence that this has a major effect on outcomes.

It is difficult to parcel out the impacts of these changes on equality. Evidence on the impact of patient choice and empowerment is fairly limited and comes mainly from the US, where care is typically managed through Health Maintenance Organizations, contracted for a fixed fee by the insurer and with strong incentives to compete on price and quality. A review of evidence by Burgess and colleagues (2005) points to two main effects: competition tends to improve quality where prices are high, but reduce it where they are low (as, for example, for Medicare patients). Studies of the UK health care market also indicate differentiation between different types of patients. Under the internal market between 1991 and 1997, two types of purchasers existed: fund-holding GPs and district health authorities. Both negotiated price reductions, but GPs tended to gain shorter waiting times and a service generally more responsive to patients' wishes and possibly of higher quality (Burgess *et al.*, 2005: 27–9). District health authorities appear also to be influenced by a concern to maintain incomes for existing facilities. The limited evidence available indicates that hospitals did not appear to avoid more difficult patients although they had economic incentives to do so. Since current policies combine a stronger role for the private sector with stringent cut-backs there is a risk that competition will be dominated by price, and will drive down quality.

The patient choice agenda appears to lead to wider choice of hospital and to more severely ill patients attending more modern and better-equipped hospitals, possibly improving outcomes. However information both on the quality of hospital and on one's own condition and prognosis (as indicated by education level) is also associated with exercising the choice to attend a more distant facility, providing suggestive evidence of a class inequality effect. A further study of waiting times for elective surgery between 1997 and 2007 shows no indication of any rise in inequality and possible evidence of a fall, although it is impossible to attribute this to any one element in the new policies (Cooper *et al.*, 2009)

While evidence is sparse, it seems that the details of the design of choice systems are crucial. Choice can improve outcomes, but needs to be exercised in the context of good information and not to be distorted by differences in

payment for treatment, which the NHS has so far avoided. How far cultural differences in confidence and assertiveness and informational inequalities can be overcome in NHS reform is at present unclear. Taken as a whole, the reform package of recent years has achieved modest gains in equality, but these may be vulnerable as spending is cut.

Education

Education was the top priority in the 1997 Labour party manifesto and high on the programme of the 2010 Coalition (Conservative Liberal Coalition Agreement, 2010). The move to budgetary decentralization, wider choice of school and greater diversity of provision that had developed since the late 1980s were vigorously pursued in the context of increases in resources and the expansion of provision in the early years, above compulsory school leaving age and in higher education. New monitoring arrangements (Ofsted) were established and targets for attainment were set. While parents and other groups were involved in the governance of a greater variety of schools the main mechanisms for empowerment were to do with open enrolment and the operation of competitive forces. Current policies for Free Schooling and the expansion of the academy programme take this further.

The specific policies to address inequalities included area-based policies (Education Action Zones, the Excellence in Cities initiatives and a range of targeted grants and interventions. In addition the trend to a more holistic approach to children's needs that culminated in the Every Child Matters (DfES, 2003) agenda promoted the inclusion of disadvantaged groups. The premium paid to local education authorities in respect of children entitled to free school meals rose rapidly between 2003–4 and 2006–7 at about 13 per cent a year above the increases in the basic allowance although some authorities do not pass the full amount into the schools teaching those children (Sibieta *et al.*, 2008). The 2010 government has introduced a pupil premium of initially £430 for free school meal and looked after children (DfE, 2011), continuing and possibly expanding this policy.

In general, these policies have again achieved real but modest improvements, difficult to disentangle from existing trends. The rate of increase in GCSE A–C grades was about 1 per cent a year, the same as under the previous government, with real gains at the primary level, slightly below the government's targets. There is some indication that the rate of improvement at the secondary level has increased since 2004–5, suggesting that improvements at the primary level

are now feeding through (Lupton *et al.* in Hills *et al.*, 2009: 77). This has been particularly striking in the most deprived schools. In schools where a third or more of children receive free school meals, the proportion of children attaining five or more A–C GCSEs has risen from about 20 to about 40 per cent between 1999 and 2005 (Lupton *et al.*, 2009: Figure 4.3). Sharp improvements are also evident in Excellence in Cities schools.

When the focus moves from schools with high proportions of deprived children to the children themselves outcomes are less impressive, possibly because the policies targeted by area miss many deprived individuals. The achievement gap between those receiving and not receiving free meals on the five GCSE measure fell from 31 to 27 percentage points between 2002 and 2007 (Lupton *et al.* 2009: Table 4.2).

Strategies to expand participation for 16–19-year-olds, including means-tested Educational Maintenance Allowances (EMAs) and changes to the curriculum, and in higher education, strong incentives for universities to offer more places, targeted support for those from poorer areas and means-tested support for students have enjoyed some success. There is evidence that EMAs encourage poorer school students to stay on, although the overall increase in education for 16–19-year-olds has been limited, (Lupton *et al.*, 2009: 82; Middleton *et al.*, 2005). Participation in higher education has also improved from 39 per cent of the age group in 1999/00 to 43 per cent by 2007–8 (DIUS, 2009) and the percentage of entrants from the lower socio-economic groups has increased from 28.5 to 29.5 per cent between 2003/4 and 2007–8, with a corresponding increase in entrants from state schools (HESA, 2010, see Lupton *et al.*, 2009: Table 4.4). Targeted EMA support has been cut back sharply. Taken together Pupil premium and the new means-tested support for low-income students staying on beyond minimum leaving age are set at about one-third of previous spending levels. They appear unlikely to compensate cut-backs in local government support for deprived schools.

The conflicts between empowerment and equality are well established in educational research. When parents are able to choose between competing providers, more middle-class parents appear to exercise choice more advantageously and over a wider range (Ball, 2008). Research in London in the 1990s showed that middle-class children are more likely to exercise effective choice over a greater number of schools, travelling further to school than their working-class counterparts (Gewirth *et al.*, 1995). A detailed analysis of school choice for 2001–2 showed that only about half of all pupils attend their nearest available school. Again, ‘as the quality of the local school is lower, children

from affluent families are less likely to go there' (Burgess *et al.*, 2006: 14). This indicates that the system at that time, consisting of open enrolment moderated by local authority or governors' (in the case of Trust and Foundation schools) decisions about school access and the number of places to be available was not working effectively to advance equality. However it is also established that neighbourhood schooling leads to choice by estate agent with one study showing a 20 per cent house price premium in a popular school's catchment area (Leech and Campos, 2003). Arguably greater diversity and autonomy in provision may facilitate choice by those on lower incomes to operate more effectively.

More recently evidence has emerged 'that faith schools have more advantaged intakes than their surrounding area, (Townsend *et al.*, 1972) and that more able pupils do better than less able pupils in specialist schools (Levacic and Jenkins (2004), quoted in Lupton, 2009: 74). More recent work for the Sutton Trust shows that 'faith schools have more affluent intakes than the average for the areas in which they are located' (Asthana, 2010). Partly this is a matter of finance, suggesting support for travel for less advantaged children. However cultural factors and pupil selection by over-subscribed schools both play a role, suggesting that stringent monitoring of selection or allocation of places by lot would also be helpful. The point is reinforced by more recent work indicating that parents from very different social classes have markedly similar preferences in education, prioritizing high academic standards (Allen and Burgess, 2010). 'The big driver of differential access to better schools is the quality of schools nearby to where the families live' (Burgess *et al.*, 2009: 33).

Similar factors operate in higher education. Working-class students were roughly one and three quarter times more likely to attend lower status post 1992 universities in 2006–7 and the gap had not narrowed since 2002–3 (Lupton, 2009: 86; UCAS, 2008). Issues of class advantage have been established as a major feature of education for a considerable period. The evidence of improvements in equality alongside indications of adverse selection as schooling becomes more diverse suggest that it is possible to go some way in countering opportunities for middle-class people to use their cultural capital and resources to get a better choice of school. Empowerment through choice need not necessarily increase inequalities if top-down resourcing, quality and inspection policies are pursued vigorously. All this indicates that further progress towards greater equality may require stronger policies to counter middle-class advantage. This is harder to achieve in a more decentralized system in which income inequalities between individual players are steadily increasing and in which spending on the service is heavily constrained.

Early years

The strategy to expand and improve the quality of childcare was part of range of programmes with two goals: to address issues of child poverty and deprivation and to enable parents (especially mothers and single parents) to participate in paid work. The National Childcare Strategy from 1998 is of interest because it is an innovative policy (no previous government had taken responsibility for making childcare available) and because it sought to expand responsiveness and accountability primarily through market choice. For providers the strategy facilitated the development of new nurseries through funding and business loans. For users, the Childcare Tax Credit subsidized up to 70 per cent of costs for those on low incomes. In addition, government funded the first 12.5 (later 15) hours of care for three- and four-year-olds for all, introduced Ofsted inspection of providers and established Sure Start programmes in the poorest fifth of wards. These integrated and supplemented existing services to provide support and care with a strong local element in management and consultation and later developed into a national programme to provide locally managed children's centres. Stewart (in Hills *et al.*, 2009: Table 3.1) estimates that funding for care and provision for under fives more than doubled from 0.21 to 0.47 per cent of GDP between 1997–98 and 2006–7, while cash benefits in respect of children rose from 1.76 to 2.31 per cent, about half of the money allocated through income related entitlement at the beginning of the period and two-thirds by the end. Local government support for early years and for young people has tended to be given high priority in allocating the 27 per cent spending cuts imposed by the Coalition between 2010 and 2014 but has nonetheless suffered sharp cutbacks, averaging 14 and 22 per cent respectively (LGA, 2011: Table 2). Child benefit has been frozen for two years and Childcare Tax Credit cut back (Yeates *et al.*, 2011).

These initiatives had achieved a massive expansion in childcare places, from some 230,000–595,000 between 1991 and 2007, the majority in day nurseries. Childminder provision remained roughly constant (DCSF, 2008). It is unclear whether this level satisfies effective demand (Hakim *et al.*, 2008). In relation to equality considerations, the proportion of households reporting that they were deterred from using childcare by cost fell from 31 to 22 per cent between 1999 and 2007 (Kazimirski *et al.*, 2007). Take-up of the childcare element of Tax Credit has improved from 23 per cent of those eligible in 2004 to 30 per cent in 2008 (Stewart, 2009: 63). One reason for low take-up may be that the element covers up to 80 per cent of costs. The requirement to fund a proportion may be a disincentive. Free places for three- and four-year-olds have had a high

take-up suggesting that childcare as such is valued. There is some indication of a slow improvement in overall quality as measured by inspection results and qualification levels (Stewart, 2009: 65). The link between class and attainment remains obdurate: for the cohort born in 1970 high social class groups with low initial test scores had overtaken low social class groups with high test scores by age seven and the same is true for those born 30 years later (Hills, 2009). Assessment of the impact of the early years strategy on such entrenched issues may be premature.

It is difficult to find evidence of the use of middle-class cultural capital in relation to access to early years provision. Since there was no commitment to a national service, middle-class financial advantage previously led to superior access to child care in a more or less free market. The 1997 government's programme effectively extended access to day nursery provision although there does appear to be a cash constraint for those unable to top-up costs from the Tax Credit subsidy.

The early years strategy has succeeded in expanding the number of providers rapidly without damaging quality through a combination of centralized resources, local involvement and individual empowerment. It has had some effect in promoting greater equality in access, limited by cost considerations. One issue is that the area-based intervention of Sure Start led to a national programme unlike health care and education where area targeting was less of a test-bed for system-wide innovations. While real choices remain, outcomes are likely to be more unequal since the provision targeted on low-income areas and households has been reduced.

Social care and individual budgets

A further innovation, designed to enhance responsiveness and individual control, is personal budgeting in social care. This system replaces means-tested subsidy for access to local authority or privately provided services. It simply allocates the relevant resources to entitled individuals in respect of their needs so that they may choose how to spend them, with or without advice. This approach originated in the 1996 Community Care Act and has been trialled across social care with positive results in terms of quality of life, personalization of services and cost savings (Glendenning *et al.*, 2008; Hatton *et al.*, 2008; Glasby *et al.*, 2009; SCIE, 2011a). It is currently being rolled out nationally and the principle extended to other areas of provision, such as the DWP Direct Payment system for people with disabilities (HM Government, 2009).

The overview of trials in a number of authorities suggest real advantages, both in user satisfaction and in cost-efficiency. There is no clear evidence on the impact on social inequality, although it is suggested that access to individual budgets decided on assessment of need will provide a more transparent way of ensuring that resources are allocated fairly and have potential for extension to health care and elsewhere in public services (Glasby *et al.*, 2009).

A review of studies in the UK and overseas (including Germany, where social insurance-based payments towards social care needs have been available for some time) points to 'emerging international evidence that self-directed care can lead to health gains and consequent efficiency gains' (SCIE, 2009). However it also points out that 'brokerage and support is needed' to assist vulnerable people in accessing services and that 'the infrastructure is not yet sufficiently well-developed in the UK'. Personal assistants are typically low paid and poorly qualified. A review of evidence on studies of patient preferences for decision-making found that younger and more middle-class users were more likely to welcome this than older and less well-educated people (Coulter, 2002). The more knowledgeable and self-confident individuals are and the more predictable their needs, the more able they feel to play a large part in decisions on the package of services they need; less confident groups, particularly older people and those with conditions that are difficult to manage, are more equivocal (SCIE, 2011b; see Glendinning *et al.*, 2009). However attitude survey evidence indicates that most people and particularly working-class people want more choice in public services, although they are much less inclined to support competitive markets and the inclusion of diverse, private and public providers (Curtice and Health, 2009).

The level of enthusiasm is unclear, and the choice and empowerment desired by users may differ from that promoted by reformers. This perspective is supported by indications that consumerist reforms may actually undermine long-term trust because providers may be seen as committed more to competitive success than the interests of the patient (Taylor-Gooby, 2009). These considerations suggest that the successful development to this approach requires support for individual budget-holders and a more substantial market providing effective choice between providers of adequate quality. This will require investment which may balance the savings of up to 15 per cent identified in pilots.

A further point is the risk of fraud when public money is spent by a great diversity of relatively naïve users. An earlier experiment in the area of adult training, Individual Learning Accounts, was closed prematurely due to concerns about widespread fraud by course providers (BIS, 2001). Perhaps

more important are the substantial uncertainties about the extent to which state resources will cover the needs of users, so that the financial burden of topping up Care Accounts may fall disproportionately on lower income groups, and this is a particular concern at a time of austerity. The Social Care Institute for Excellence (SCIE) report simply states that 'reliable evidence on long-term care costs is not yet available' (SCIE, 2009).

The expansion of individual choice through personalized budgets across areas of routine NHS treatment takes the process further. The real issues concern whether budgets remain adequate, whether some groups need to make co-payments and cannot afford them and whether those with more cultural capital can exploit contacts or make better-informed choices.

Public service reforms and inequality

This brief review suggests that, while the reforms of recent years have enjoyed some success in improving overall outcomes, achievements in narrowing the gap between the most advantaged and disadvantaged groups have been partial, even when substantial resources have been directed to this end. Progress towards greater equality is limited in health care, more marked in education, probably real in early years provision and at present uncertain in individual budgeting in social care. There are strong indications that reliance on area-based initiatives in the first two areas weakened potential outcomes. However the area-based Sure Start programme does appear to have provided a good basis for the development of children's centres and other initiatives. Just as progress towards the child poverty targets has slowed since 2004 because government is no longer increasing resources for Tax Credits, progress towards equality targets in health care and education has been limited because government has not developed beyond area targeted policies.

At the time of writing severe cut-backs are affecting public spending across all these areas. A renewed emphasis on localism and on privatization is directing policy. User choice is a prominent theme in this. It is difficult to assess the impact of these changes until good evidence on outcomes emerges. All the indications are that the cut-backs will reduce or eliminate much of the co-ordination and targeted support that appears to have played the strongest role in the advances towards greater inequality that have been made. Social inequalities appear likely to grow more severe as a result of changes in labour markets and household structures and retrenchment in redistributive social

housing and benefit programmes. Choice and diversity of provision are set in a context of increasing social divisions.

Four points may be made:

- The modest successes achieved appear to depend on the combination of top-down and bottom-up interventions. It is difficult to attribute any progress toward equality to the operation of empowerment and choice policies independently from extra resources, inspections and targeted programmes. This point is of particular relevance at a time of austerity when part of the case for empowerment is linked to concerns about weak productivity increases and public spending 'burdens'. Choice is predicated on the availability of a wide range of providers of with assured minimum standards and accessibility and policies to develop and sustain this.
- Consideration needs to be given to mechanisms which will counter inequalities in resources and cultural capital, for example in travelling to desirable schools and clinics, in gaining access to and assessing relevant information or in ensuring that users from all backgrounds are equally attractive to providers.
- The reforms discussed above have gone some way in this direction but in none of them are the problems of privilege for particular groups in an open choice system entirely resolved. This is particularly evident in education, where the supply of places in the most desirable schools has proved hard to expand. Current approaches address the issue by seeking to improve information, support in decisions and access for disadvantaged groups. Policies to restrict the play of cultural and cash resources by for example banning private travel to facilities, using lottery allocation for over-subscribed resources or preventing providers from accessing information that has a bearing on user class background, might advance equality. However, these seem unlikely to gain support in a liberal society.
- The policies of the 2010 government stress privatization, localism and individual control, and vigorously scrutinize redistributive benefits and centrally controlled programmes directed to poorer groups. When evidence on outcomes is available, a comparison between the impact of the coalition's policies and those of the previous government will provide insight into the extent to which the choice agenda is compatible with equality and social justice in an unequal society.

The indications so far are that empowerment through choice can contribute to mitigating inequality, but only as part of a policy package which includes

intrusive and expensive government interventions. Policies that make the poor more equal by allowing them greater consumer choice as equal actors in a welfare market place are attractive to both service users and to policy-makers. This review of recent evidence indicates that such equality will not extend to more equal outcomes unless reformers are willing to take the hard decisions involved in raising more resources from better off groups and directing them towards those who are less advantaged.