Better Schools and Hospitals

Why parent and patient choice will work

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CHAPTER ONE

INTRODUCTION

OVER THE LAST FEW YEARS, authors published by the CPS have been in the vanguard of arguing that major reforms are needed to deliver better education and healthcare in the UK.[1] Their policy proposals have been based on the following principles:

- that governments should not attempt to micro-manage schools and hospitals;
- that parents and patients should have the freedom to choose the school or hospital they prefer;
- and that schools and hospitals should have the freedom to respond to the preferences of parents and patients.

These proposals have been made at a time of significantly increased government spending on education and the NHS, increases which have yet to show any proportionate improvement in outcomes. It is becoming accepted therefore that further attempts to improve education and healthcare through more funding and 'better management' of the current structures will fail. All they can do is to impose more central controls, targets and costs on already over-burdened teachers, doctors and nurses.

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1 CPS pamphlets on this subject include Sean Williams, *Freedom for Schools*, 2000; Norman Blackwell, *Towards Smaller Government*, 2001; Norman Blackwell and Daniel Kruger, *Better Healthcare for All* 2002; John Redwood, *Power to Parents*, 2002; Maurice Slevin, *Resuscitating the NHS*, 2003; Harriet Sergeant, *Managing not to manage*, 2003; and Norman Blackwell, *Freedom and responsibility*, 2003.

The present Government has accepted the need for some limited freedoms for hospitals, for example, with its Foundation Hospitals policy; and it has accepted the principle of patients being treated by private health facilities under the NHS. And again, while progress is limited, it has also accepted the principle of state schools being run by private sector operators, and state-funded pupils attending private schools for selected A-level tuition. More encouragingly, the Conservative Party has now officially adopted a policy of pupil and patient choice by entitling individuals to use their state funding, subject to certain constraints, at the school or hospital of their choice in either the state or independent sectors.

However, offering choice through "passports", "vouchers" or their equivalent is not the complete solution. Indeed if parents or patients are offered choice but the supply of desirable school places and hospitals remains constrained, the benefit of choice is illusory: badly performing schools and hospitals will face no pressure to improve. What people want is not choice *per se* but better schools and better hospitals.

Schools and hospitals therefore must be free to respond to local demand. The professionals, not a centrally-managed bureaucracy, must have managerial control and accountability. And good schools and hospitals must be allowed to expand, and new entrants allowed to set up wherever they see an unfulfilled demand. It is this combination of freed-up supply from independent schools and hospitals together with personal choice that creates the powerful conditions where standards can be transformed.

This document aims to provide a straightforward, practical guide to the questions being asked about how these policies would work in practice – and whether they should and would command popular support. It concludes that a bold approach will be essential if the full benefits of this policy are to be achieved.[2]

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[2] See Appendix III for a detailed discussion of why and how parent and patient choice leads to better schools and hospitals.

CHAPTER 2

FREEDOM AND CHOICE IN SCHOOLS

The idea of money following the pupil is not revolutionary. The last Conservative Government went some way down this road with the development of Grant Maintained (or GM) schools, which the Labour Government subsequently abolished.[3]

Since then, however, the level of central government intervention in schools has multiplied – with an enormous burden of plans, initiatives and targets on top of inspections, tests and tightly defined curriculum. Yet despite this, and the statistics claiming ever more children with successful examination grades, there is a widespread sense that many schools are not delivering the quality of education that parents want – and too many children, particularly in less advantaged inner city areas, are failing to get the basic standard of education they need.

This, then, is the environment in which freeing up schools and ensuring that money follows the pupil is offered as a radical solution. But can it work, and will it be accepted by the electorate? This chapter sets out to answer the key questions.

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[3] See Appendix I for a comparison of the proposals suggested in this paper with the freedoms enjoyed by GM schools until 1997.

1. What is meant by "passports", "vouchers" and parental choice? Isn't it all too complicated? (And is there a clear, workable proposition?)

The concept is simple and convincing, with obvious benefits. Yet some of the details of its implementation are complex, not least because to achieve the benefits, parental choice must go hand in hand with the liberating of schools from state bureaucracy.

Problem: Good schools and teachers are currently being stifled by central targets and plans. Parents feel powerless if the local school their children are allocated to is failing them. Those who cannot afford to pay for private education are trapped.

Solution: All schools should become independent schools run by their head teacher under a local board. Teachers would be free to focus on improving the quality of teaching and responding to the needs of their pupils. Parents would then be given the right to choose whether they continue to send their child to that school, or to choose any other school that can offer them a place at the same cost. All schools would effectively become independent schools, receiving income from the government (or schools funding agency) in the form of a payment for each pupil on their roll (just as GM schools did). The current distinction between state and independent schools would disappear, and all parents would have a much wider choice.

Schools would then have the freedom and the incentive to deliver the quality of education parents want, and the opportunity to expand if they are successful in attracting more pupils; and since waste from bureaucratic overheads would be removed, more taxpayers money would reach the classroom. New independent schools would also be set up offering additional places and choice to parents, with places funded by the state. Parents would have the right to take their share of the education budget and apply to the school that they think is best for their child. All schools should improve, and a range of choice that is currently only available to the rich would be made available to all. Who could object to that?

2. How can good schools take more pupils? How can there be more choice without more capacity? Where will that come from? Who will fund it?

More popular schools would be more likely to take more pupils where they can, as this would bring them more income to pay for more teachers and other resources. Under the current 'surplus places rule' they have been denied that opportunity, if another school in the area was under-subscribed. Freed from this restriction, popular schools would in some cases be able to expand slightly without new classrooms just by increasing their intake and average class size.[4] In other cases, they may wish to add on new classrooms where space allows. Where the economics support it, PFI-type funding could be used to fund new facilities based on future income expectations. Alternatively, the government (through a schools funding agency) could make loan capital available to schools where they can demonstrate that they have unmet demand.

The average annual cost per pupil of independent day schools was £6,150 in 2003, compared to a current annual per capita cost of state schooling of over £5,650.[5] And with large projected government spending increases, the annual per capita cost in the state sector is expected to reach £7,370 in three years time. It is therefore probable that the rising value of the "passport" or "voucher" will enable an increasing number of established independent schools to offer places in return for the same per-pupil government payment. In addition, this system could encourage the establishment of new schools: voluntary groups, charities, parental co-operatives and other organisations might identify and try to meet a local need.

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4 There is no evidence that smaller classes necessarily improve standards: the quality of teaching is much more important. See J. Marks, *Standards and spending: dispelling the spending orthodoxy*, CPS, 2002.

5 See Appendix V for details of latest calculations.

Payments for both former state schools and independent schools would of course vary by age group to reflect the different costs involved – estimated to be 10% lower than the average for junior schools and 10% more for senior schools. Sixth form pupils would also attract a special rate. Some high cost areas, such as London, might also need a 'London weighting' – but as far as possible the basic payment would be kept to as simple a formula as possible.

3. Won't it take time for these choices to develop and for standards to improve?

Giving headteachers the freedom to start shaping their own policies and school programmes would have an immediate impact. Experience suggests that, even in the toughest schools, a determined new headteacher with the freedom to act can make a difference in a year or two.

Expanding choice would, of course, take longer – and new schools would take time to establish. But not all new schools need to start off in a costly, purpose-built school building: many independent schools currently work effectively out of converted large houses, and most start up with temporary premises.

To overcome property barriers, a new legal requirement could be set for local authorities to help make sites available for new schools – subject to the existence of a viable proposal – within a reasonable period (say, five years). Properties could be leased to schools if they did not have their own funding, with a capital sum provided from central government if necessary. To ensure availability of schools in urban areas with expensive land costs, these would either need to receive an explicit capital top-up on the per-pupil payment (where they were occupying private or market cost premises); or continue to get a public subsidy through below market lease costs.

This policy does not require most children to move to a different school in order for it to work in raising standards. The power of choice is an important driver of standards, even if many people decide not to exercise it.

Every school would be freed from much of the current state bureaucracy, and would have the incentive to make itself as good as possible in order to keep and attract pupils. If a school starts losing pupils that would trigger action to improve that school or ultimately to pass control of the school to another organisation with plans to run it better. Some good schools may feel able to take over other similar schools and apply their methods to improving them in order to have scope for growth: all pupils would ultimately benefit from the working of a competitive market.

4. What happens to schools that can't compete? Won't they lose resources and just get worse?

Of course schools that fail to attract pupils – because of low achievement levels, indiscipline or other failings – would initially lose pupils to more popular schools if parents were no longer forced to send their children there. This movement would leave failing schools with reducing rolls and excess costs.

A failing school would be likely to take several years to recover financially. To meet this problem, a central funding agency would be established to provide temporary grants (over and above per-pupil funding) to those schools that needed to balance their books. These additional grants would require a clear turnaround plan that would be monitored by the central funding agency (failing schools already receive additional government funding).

However, the cost need not be prohibitive. Let us assume that the expansion of popular schools (or movement to independent schools) left some 200,000 empty places at failing state schools. This would be equivalent to increasing the whole of the present independent sector by 50%. The short-term cost (at about £5,600 per head) would be around £1 billion if no cost reductions were achieved; but adjustments would be expected to follow very quickly. A continuing financial imbalance would be the trigger for improvement or new management. Whereas at present a failing school can continue operating indefinitely, a school that continues to lose pupils will be

forced to act – either by the Board itself recognising parental pressure, or by the central funding agency refusing to grant additional financial support until the school is reconstituted.

Schools that are able to recruit a new head teacher and staff, and create a fresh start, can often achieve a remarkable transformation over a relatively short period. In some cases they might be taken over by the equivalent of specialist school foundations (such as City Technology Colleges) with the support and sponsorship of business backing. In the US, school management organisations have been created which specialise in taking over failing schools and turning them round in collaboration with local parents – both from the not-for-profit and for-profit sectors. Where there are competing offers to take over a failing school, it would be appropriate for parents to be balloted on the option they most preferred.

Of course if a school genuinely needs to shrink in size because of changing demographics or because other more attractive schools had permanently reduced its intake, its turnaround plan would need to reflect this scaling back in staff and resources.

5. How does it help underprivileged children in inner cities? What choice will they have? What about special needs?

The scheme would be particularly effective in helping children from under-privileged families and deprived areas. These are the children who today are most likely to be served worst by poor schools, and who have no opportunity to escape. This is the group that the scheme would help most. Better-off families often have access to a wider variety of schools (not least by moving house so that they live in the catchment area of better schools); are more articulate in demanding high standards; and are more likely to be able to afford private schooling as an escape route if the state sector cannot deliver.

Under these proposals, parents in catchment areas with schools of low standards would have more chance of gaining a place for their child at a school that was to expand its intake. New schools may have been set up to offer a state-funded alternative choice. And, the pressures on failing schools would be likely to encourage them to improve standards: ultimately even those children whose parents took no action would benefit too.

As stated above, the scheme would allow for schools operating in high-cost inner city areas to have additional payments per pupil. Where transport is likely to be an issue in enabling children to take advantage of a wider choice of schools, there may be a case for extending the right to free public transport for school children. In some areas, there may also be an argument for extending school bus services.

The scheme would also include an additional payment, as now, to cover the additional cost of special needs children so that schools would be able to make appropriate provision for those properly diagnosed with those needs.

6. Should parents be allowed to chose a place at an independent school? Surely this will be seen as a subsidy for the rich? Should the choice be limited to state-maintained schools to prevent this?

Limiting choice to schools currently in the state sector makes no sense: the power of choice in raising overall standards will be greatest when there is the maximum scope for alternative options and for new school places to be created. Artificially limiting choice to state schools would mean it would take far longer for any changes to have any real impact, would exclude innovative groups with new approaches, and would work to the disadvantage of those in disadvantaged areas where the choice of state schools is poorest.

Furthermore, if all schools were freed from central control and were enabled to operate as independent schools, there would cease to be any real distinction between former state schools and former

independent schools. They would all depend on the payment they received from the number of pupils on their roll. The ownership structures of schools may be extremely varied, ranging from community not-for profit organisations, to charities to private businesses. However, in order to give parents a 'no–quibble guarantee' of continued availability of free school places, former state schools would not be allowed to charge more per pupil than the amount funded by government. However, since – as noted earlier – the average cost of a place at a fee paying independent school is now roughly the same as the full cost in the state sector, there should be many independent schools which are able and willing to offer choice in return for the same per pupil payment.

Some better-off parents would use the freedom to take free places at schools where they would previously have paid. However these parents are currently already paying twice for their children's education – once through the tax system and then again out of post-tax income – and often have to make considerable sacrifices to do so.

The so-called 'deadweight cost' is not large enough to offset these benefits. There are currently some 589,000 children in England educated in the independent schools.[6] If 30% of these were able to substitute state-funded places at about £5,600 a head, the deadweight cost would be under £1 billion. It would be perverse to deny choice and opportunity to the much larger group of children currently in state education just to avoid giving a financial advantage to a few – particularly since many of these are families who struggle and make sacrifices to pay independent fees now.

According to recent polling, the majority of adults from those with below average incomes would aspire to private schooling if they could afford it.[7]

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6 Data for the number of children attending independent schools in England can be found at www.dfes.gov.uk/trends.

7 See Appendix IV for details of polling evidence.

7. Should parents be able to top up the cost to help pay for places at higher fee level independent schools?

The proposals currently put forward by the Conservative Party would exclude this. However, other options might include allowing a modest top-up, or limiting the ability to top up to exclude those parents with higher earnings.

In principle, however, there should be no fundamental objection to allowing parents to 'top up' the state sector cost on the condition that parents who cannot afford to do so are also offered a wider range of choice. Also, many parents who today cannot afford the full cost might welcome the chance to contribute a bit more. If so, the potential gain in choice offered to many people on modest incomes could be seen as far more significant than the gain to a small number of better-off parents.

However, this could raise the short-term deadweight cost to over £2 billion (assuming every parent with a pupil currently in independent education claimed it). It would also substantially increase the short-term cost of paying for empty places left in less popular state funded schools. Budget constraints might therefore require any top-up capability to be deferred until the scale of any potential movement is established, and the ability of the independent sector to offer places at the standard per-pupil cost has been demonstrated.

8. What freedoms will schools have – for example on admissions policy ? How does the policy differ from growing specialist schools and City Academies (or the old GM approach)?

The granting of independence to state-maintained schools and the adoption of per-pupil funding would not necessarily imply any change in admissions policies. Schools should be able, as now, to continue with a 'first come first served' policy, or give preference to siblings or those from nearby; they may also, as current specialist schools, choose to select a limited portion of their intake

based on particular ability or aptitude. Those that have previously operated as selective schools, such as the remaining grammar schools, should be able to continue to operate on that basis.

However, as schools gain their independence, it is anticipated that they would have greater freedom, giving all schools the freedoms currently enjoyed by specialist schools or previous GM schools.[8] The head teacher would control staffing, training of teachers, the balance of the curriculum and most financial aspects. Over time, it might also be expected that head teachers and governing boards would seek to develop their own admissions policy which reflected the ethos of the school, the needs of the community that they served and their ability to expand their intake. This evolving diversity would be welcome.

As with previous GM schools, funding will be based on the principle of 'money follows the pupil'. However the major difference in what is proposed now is that the money would also follow the pupil to an independent school that has never been part of the state sector.

9. What difference will it make to standards? Shouldn't we focus on making schools better?

Much of the difference between a good school and a bad school can be explained by three factors: the quality and leadership of the head teacher; the ethos and teaching methods applied; and the support offered by parents (the capabilities and skills of individual teachers are also important of course, but their performance can be hugely affected by the environment set by these other factors). What practical steps can be taken to ensure that poor head teachers and a poor teaching environment are replaced with better ones?

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[8] See Appendix I for a comparison of these proposals with GM status schools.

Centrally-imposed targets, plans and methodologies have failed to achieve these outcomes. Instead, good head teachers need the freedom to develop the school in the way that best meets the needs of the local children, free from central bureaucracy. And parents whose children are trapped in failing schools need to be able to take their children to a better school. As noted above, it is these pressures which are most likely to provide the catalyst for change in failing schools . And they will also provide the incentive for new schools with innovative approaches to emerge.

10. Who will run the schools if we make them independent? Will they be taken over by private companies? Who owns the assets?

To be granted independence, schools would need to demonstrate that they had appropriate structures and governance.

The most likely default option would be for existing state schools to be granted independence as not-for-profit organisations operating as charitable trusts under an independent board. There is room for debate about how those boards should best be constituted, but the objective should be to have people who can bring knowledge and advice from business and public sector management alongside local parent and community representatives and staff.

The primary roles of the Board would be to appoint the head teacher; to agree the plans, approach and budget; and to monitor both educational and financial performance. The Board would have responsibility for recognising when the school was not delivering what parents want, and for taking action – including replacing the head teacher – if remedial steps were required.

Some schools might operate in a similar way to current specialist schools (such as City Technology Colleges) with major business sponsors; others might come under the wing of charitable, educational or church foundations.

New schools could be set up under any of these models, or could be run by private sector 'for-profit' organisations if they were able to

compete for pupils within the same funding cost. Private sector organisations could also take over former state sector schools if they were able to provide an attractive educational offer. Any such change in status would require the approval of the parents to proceed.

However the assets of former state schools would need to be protected to avoid the danger of any type of asset-stripping behaviour. Depending on the nature of the organisation taking over the running of the schools, this could either be achieved by placing the assets in a restrictive trust, or by leaving the freehold ownership in the public sector. In either case, the organisations running the schools would be granted long leases on terms that grandfather existing charges – but with freedom to agree alternative sites or reflect changing capacity requirements.

11. Isn't there a risk we will encourage too many divisive religious schools?

The requirements of state-funded education would continue to be set out under legislation, including minimum curriculum requirements. Any school offering education under the state-funded scheme would have to register with the schools funding agency, and show that it met these requirements. It is open to any government now or in the future to place general requirements or restrictions on schools on issues such as religious tolerance, language requirements or other curriculum content.

However many parents do choose now to send their children to schools which emphasise a particular religious philosophy – including Catholic and Church of England schools – and a government which believes in personal choice and freedom would uphold those rights so long as they do not become divisive.

12. How will LEAs and local council members respond? Won't they oppose this?

At present, Local Education Authorities act as a distributor of government funds and services to schools in their area. Recently,

their influence over education policy has been marginalised, with all the important decisions, and most of the controls and targets being set by central government. Inefficient or politically-motivated local authorities can, however, act as a block on schools which want to set their own course. It was for that reason that, in the 1990s, Grant Maintained Schools were first allowed to escape from local authority control and opt for direct funding from the funding agency for schools.

The true local autonomy proposed here leaves head teachers free to create the conditions for success in their own schools while the real power of choice in the hands of parents. Local Authorities can and should continue to offer common services to schools where these can be provided efficiently across an area, but to avoid inefficient public sector monopolies the schools should be free to contract with other providers for these services if they can get a better deal by so doing. Local authorities would also have the responsibility (and obligation) to provide sites for new schools to set up where there is a clear demand for them – and they would continue to be the owner and lessor of school premises where these have been provided by the local authority. As part of their child care responsibilities, they would also continue to have a residual responsibility to find places for children whose parents claim they were unable to do so – including disruptive and special needs cases.

Few bureaucracies welcome giving up powers that they have previously held. However, by removing themselves from the intermediary role in distributing central funds to schools, local councils will be able to operate with budgets that are more closely matched to their local revenue raising – and will therefore be able to be given much more autonomy in their overall finances. This will enable much more effective local democracy, with councils able to concentrate on those services where they have a real role to play in meeting local needs.

13. Can headteachers cope? Shouldn't we let them get on and teach?

Most head teachers are already overloaded with bureaucracy and form-filling. Most would welcome the chance to escape from under this managerial burden and take more direct control over their schools and their budgets – as many did with Grant Maintained schools.

Of course there will be some who are not equipped to cope with all the financial and managerial tasks. However, like independent schools today, most schools would expect to employ a bursar or accountant to deal with much of the day-to-day administration – leaving the head teacher to concentrate on staff and pupils.

As a safeguard, the competence of the head teacher and his support staff would be one of the criteria that should be used in granting schools independent status, along with the nature of the Board and other governance arrangements. Training programmes should also be available to assist those head teachers who would benefit from broader development.

14. Won't per-pupil funding mean a huge, costly bureaucracy?

These proposals do not need to involve much new bureaucracy: greater autonomy for schools means that much of the central bureaucracy that currently exists can and should be swept away. Nor is the distribution of physical payment vouchers necessary – as with the old GM schools, all that is required is a national funding agency whose primary role is to distribute government funding to schools each term based on the number of pupils enrolled. This agency would also approve loan capital to schools which could demonstrate additional capacity requirements and were unable to raise funding externally. And it would agree transition grants to cover temporary budget deficits where schools were having to adjust to a fall in pupil numbers.

15. Won't opponents dismiss this as privatisation?
Opponents may attempt to say that per-pupil funding is a move to making people pay for education. That is simply not true – and can be dismissed with a simple "no-quibble guarantee" that everyone would continue to have access to a free school place. Most people would not mind who provides public services as long as they were good quality, and continued to be provided on ability or need in the same way as today.

16. Does it work anywhere else, or is it just fancy theory?
Yes. "Passport" or "voucher" schemes where there is a choice-driven 'money follows the pupil' scheme are already in operation in several countries.

In the US, Milwaukee's Parental Choice Programme is the oldest and largest voucher scheme and empowers poor parents to buy places in private schools if they are unhappy with standards in the city's public sector schools. Vouchers are popular, and areas where the scheme has operated now have demonstrably higher standards than those areas where choice has remained restricted.[9]

New Zealand started a modest but popular voucher programme in the mid 1990s. It has been targeted at children from low-income families.

In Europe, similar schemes operate in the Netherlands, Denmark and Sweden. In the Netherlands, parents are free to choose a school in either the public or private sector nationwide. Three quarters of secondary pupils are educated in independent schools and completely paid for by the state. There is no visible 'voucher', but the decision by parents to choose a particular school triggers a per capita payment to that school from the Ministry of Education. Parental topping up is not allowed.

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[9] "School Choice and School Competition: Evidence from the United States", by C. Hoxby, *Swedish Economic Policy Review 10*, 2003.

In Denmark, children can also opt for independent schools. Unlike the Netherlands, they do not have all the costs of private schooling reimbursed but can have a large proportion (between 80% and 85%) paid for by the state. Many independent schools do therefore charge top-up fees, though poorer children can obtain scholarships so that their schooling is free. Following the scheme's introduction in the 1980s, the number of parents choosing independent schools rose by 50%. Sweden introduced its "voucher" scheme in the early 1990's.

The notion that the state paying for education does not mean the state running schools is increasingly established. In the US, for example, privately-run schools have been set up to 'take over' failing state schools in inner city areas and turn them around – with strong parental support. Even the UK government has set up initial pilots to test private sector management of state schools. An average of one in ten of all schools across the OECD are now publicly-financed but privately-managed – a proportion that reaches 58% in Belgium and close to 75% in both Holland and Denmark described above.

17. Isn't this too risky for any political party to put to the electorate?

It is unlikely that many people will grasp a policy like this in sufficient detail for it to win 'single issue' popular support in advance; popular support is more likely to follow after a period of years when it has been demonstrated to work.

However any potential government will need to convince the electorate that it has proposals which it is convinced will make a difference on the range of issues that concern people, and which are consistent with its beliefs and philosophy. Since centralised control of education has failed, this is the only policy that can be advocated with conviction by those who believe in small government and in encouraging personal freedom and responsibility.

CHAPTER 3

FREEDOM AND CHOICE IN THE NHS

AS IN EDUCATION, the recent focus on centralised targets and management initiatives has failed to deliver improved performance in the NHS. Instead, it has created a service in which health professionals feel totally weighed down bureaucracy and misdirected initiatives.[10] Can a scheme built around money following the patient reverse this, and win support from a sceptical electorate?

1. What is meant by "passports", "vouchers" and patient choice? Isn't this too complicated to explain? (And is there actually a clear, workable proposition?)

As with money following the pupil, this can be explained simply. But as with schools, its introduction can only work if it is linked to reforms to free up the providers – hospitals in this case – from centralised state management. It is this combination which would both increase choice and improve standards for everyone.

Problem: The NHS has been burdened with excessive central controls and bureaucracy which prevent hospitals using their resources efficiently to treat patients in need. This results in long waiting lists. Patients are left at the mercy of local waiting lists, with no chance of escaping from the bureaucracy.

Solution: First, free up NHS hospitals to be run by local medical and managerial teams without excessive central interference and overheads – which would enable them to treat more patients with

[10] See Harriet Sergeant, *Managing not to manage,* CPS, (2003).

the same resources. (This is the direction the Government is suggesting with Foundation Hospitals, except that in reality it has retained excessive bureaucratic controls.) Second, give patients the freedom to choose any of those hospitals that can offer them fast, convenient treatment, or to take funding equivalent to the cost of the treatment under NHS (or part of it) to a private hospital.

If the private hospital charged more than the NHS, patients would be able to top up the value transferred from the NHS with their own money rather than having to find the full cost themselves. Not only do they get faster treatment; they also move off the waiting list – so that those who cannot afford it also benefit from faster access to NHS facilities. Everyone would get better treatment. Who could object to that?

2. How can you give choice or faster treatment without more capacity? Shouldn't we just focus on more money for more doctors, nurse and facilities?

Existing capacity in both NHS and private hospitals can be used more efficiently to get more treatments at a lower cost per operation.

The waste and inefficiency caused by the unclear management responsibilities in the current NHS bureaucracy has been well documented, as has the distortion of local practices and patient care to meet the statistical norms imposed through a multitude of centralised targets.[11] The freedoms and accountabilities proposed here for local teams and professionals to run hospitals will of itself enable much improved performance within the same resources.

For example, many operating theatres and wards in NHS hospitals are not utilised as well as they might be, partly due to short-term cancellations and rearrangement of patients to free up places. Many also only operate for limited hours, constrained by a fixed budget allocation. This raises costs and extends waiting lists.

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[11] Not least by Harriet Sergeant, op. cit.

At the same time, private hospitals have facilities which are not fully utilised, and where the marginal cost of extending hours of operation is relatively low. There is also scope for specialised facilities which focus on delivering a long run of routine operations (such as hip replacements) to deliver these operations at much lower cost than when those operations are performed in general hospitals. As is already happening, facilities in Europe can also be used to provide additional capacity for NHS patients in some specialist areas. With the right framework and incentives, more treatments at low incremental costs are possible.

The current Government is already making use of these alternative suppliers to provide more operations at lower cost. Moving routine operations out of the NHS general hospital also leaves the hospital more able to cope with more demanding urgent treatments. Money following the patient will allow patients more freedom to take those options as a right where the NHS is failing to deliver. And, where they choose, patients will be able to top up the cost of treatments, allowing more use to be made of non-NHS facilities at the same cost to government.

3. Won't more choice and shorter waiting lists lead to an explosion in the NHS budget?

Any government has to set a budget for NHS spending and, as now, seek to control expenditure to meet that budget. Today, care is rationed through waiting lists on a wide range of treatments – which is an unfair and medically damaging way of controlling demand. A much clearer way of budgeting costs is for the NHS (through the National Institute for Clinical Excellence – "NICE") to define those treatments which should be available on need (taking account of the available budget) and those which are regarded as not medically necessary or not yet accepted as routinely available. This 'qualified list' approach is the way many other countries set the limits of their healthcare provision – most of whom do not have the same scale of waiting lists that the UK does.

Of course, if the total volume of operations goes up this will increase the total funding required by the NHS for a transitional period while the backlog is cleared – but once the backlog from waiting lists is reduced, the total ongoing 'demand' for operations should not be significantly higher (apart from those who sadly never get treated under a system where waiting lists are so long). All political parties accept that more resources should be provided to the NHS if they can be used efficiently – but the reality is that, extending use of independent facilities is a much more cost effective way of doing that than simply trying to push more money into the current NHS structure.

If further priority-setting is required, this is better done by local GP's and medical specialists taking explicit decisions rather than using waiting lists as a crude rationing device.

4. Who will run and own the hospitals? And how would they get paid? Isn't this privatising the NHS?

The intention is that existing NHS hospitals should be given more freedom and autonomy to provide care under NHS funding. They would then receive funding based on a set tariff for each patient/treatment they handled. The present Government's Foundation Hospitals approach, combined with their intorduction of 'payment by results', is aimed at the same objective, but has ended up imposing so many layers of control and regulation on the hospitals that their freedom to manoeuvre will be limited.

The rules for Foundation Hospitals should be simplified. Under current legislation, they have to be transferred from the NHS to new public benefit corporations with complex rules for community representation and several layers of governing Boards. This needs to be simplified to allow a wider range of voluntary and not-for-profit organisations to take management control, with the land and buildings remaining either in a protected trust or in the public sector and leased to the operator on affordable terms. The required Board structures should also be streamlined to just two levels – a governing

Board including both medical and management staff and qualified non-executive directors from the local community; and a management Board that runs the hospital on a day-to-day basis. In due course, subject to appropriate controls, the management of these hospitals might also be opened up to national organisations – in the voluntary or private sectors – where they could demonstrate that they would bring expertise and efficiency.

Finally, the range of controls and targets that will continue to be imposed on Foundation Hospitals from the Department of Health and its new regulatory bodies should be greatly reduced, with the primary regulatory oversight being on quality of medical care. The star rating system, with its distorting effect on priorities, should be scrapped.

As now, patients would normally be referred to the hospital from the primary care trust with which they were registered, but unlike now the trust (and the patient) would be free to choose any NHS hospital rather than just those with which they had contracts – this choice made possible by a single national tariff that determined a standard payment for each treatment. In addition the patient would be free to choose any independent or private hospital or clinic that was willing to accept the NHS tariff in full or part payment (subject to any budgetary limitations that might be imposed on the value of the tariff that could be transferred).

The payments to NHS and independent hospitals would continue to flow, as now, through budgets provided to Primary Care Trusts – or equivalent organisations that may evolve in future to take on NHS patient care. Capital investment could be funded through a combination of PFI-type projects based on future income streams, and through capital grants provided from the national NHS funding agency. In addition, the NHS funding agency would require an additional budget to help tide over those hospitals which have a temporary deficit from failing to adjust costs in line with their income – but would approve these through a remedial unit which would receive and monitor plans for correcting these deficits.

The entitlement to NHS health care would continue unaltered; but the provision of that healthcare that would be opened to a much wider range of providers and the choice available under the NHS would widen accordingly.

5. Won't it drain resources out of the NHS? (Or bid up their cost?)

Allowing people currently on a waiting list to take their funding to a private or independent hospital will add to the resources available to NHS patients, not reduce it. Not only are there many under-utilised facilities outside the NHS, but there are also many former NHS nursing staff who have given up working within the NHS who would welcome the opportunity to work part time in independent hospitals if the work was available. Many private facilities are also active in recruiting doctors from outside the UK to work on temporary contracts. While the growth of jobs outside the NHS hospitals could put pressure on salaries, the hospitals offering to take patients from the NHS will get the same payment tariff for each operation as the NHS pays internally – so they will only be able to pay staff more if they are more efficient.

6. How can you offer choice for emergency treatment? Won't most people still end up at the local hospital?

Of course it will still be essential, as now, to have a network of hospitals with Accident and Emergency facilities who are able to cope with medical emergencies without long travelling distances. As now, appropriate funding will need to be provided to support hospitals keeping open such facilities wherever they are a necessary part of the overall health care provision.

However, once the initial emergency treatment has been provided many patients have a lengthy hospital stay before they are allowed home – and, as sometimes happens now, they may choose to move to a different or more convenient hospital for that period, releasing emergency beds in the process. The same should be true of

many elderly patients who end up with long stays in hospitals because they are unsafe to return to their homes, but block access to beds for new patients needing more intensive hospital care.

It is also worth noting that emergency admissions account for only just over one third of all hospital admissions – the remainder, including elective surgery, could be open to patient choice if it were available.

7. What happens to hospitals that can't compete? Won't they lose resources and just get worse?

Hospitals which are less popular will, in the first instance, experience a reduction in the waiting lists for admissions. This of itself may relieve the pressure on the hospital's resources in a way that helps them to improve patient care and increase efficiency. Equally if they end up with lower waiting lists and shorter waiting times than more popular hospitals this will, of itself, tend to attract more patients back again.

However if they continue to lose patients to better hospitals this will over time reduce their income and require them to scale back some ward sizes and staff. If this is a consequence of inadequate patient care – or a reputation for poor treatment – the falling income and patient flow will be a trigger to the Hospital Board to take action in order to rectify their performance. The consequence is that all local hospitals should be under pressure to meet the best standards of the hospitals around them – and to deliver what their local community wants.

In addition there is likely to be natural pressure for hospitals to focus on speciality areas where they have the best reputation, facilities and consulting staff. Over time this will result in better use of resources and better quality care.

Furthermore, as noted above, the national NHS funding agency will need to provide temporary financial assistance to fund the budget deficits of hospitals which are unable to adjust their cost base in time, and would require a clear improvement plan from the

hospital in return. If budget overruns persist, or the independent health regulator determines that medical quality falls short of required standards, the NHS funding agency or the regulator would be empowered to step in to force a change in the Board and management – or, *in extremis*, to close down a failing hospital that was no longer required to meet the needs of its local community.

8. What happens to primary care? How do GP's fit in? Who controls the cost of treatment

Primary care is in many ways the most important element of healthcare. It would continue to play its traditional role as the referral point (or 'gatekeeper') for specialist treatment. Indeed it is essential that primary care continues to act as the overall budget holder to manage the total cost of healthcare treatment.

Individuals are already free to choose their own NHS GP or medical practice, and that would continue. GPs would continue to belong to Primary Care Trusts which would work with local hospitals to plan the nature and level of treatments likely to be required. The difference that this scheme would make is that doctors and patients would be free to choose any facility that had a place to perform hospital treatment – either for free at the NHS tariff cost, or at a private hospital that required a top-up if preferred – rather than being restricted to those NHS hospitals with whom the Primary Care Trust had a Contract.

The money flow to hospitals from the NHS funding agency could in principle go direct from the centre to the hospitals (in payment for recorded patient treatments); or be distributed via Primary Care Trusts. The advantage of the latter is that it would preserve the budgetary pressure on GPs to seek the most effective way of meeting their patient's health care requirements, including appropriate emphasis on preventative healthcare, and cost-effective use of non-hospital facilities (such as local surgeries and GP-run cottage hospitals) where they were appropriate. Without this pressure, there is a danger that the incentive for hospitals to

maximise revenue would lead them to treat more patients in hospital than was medically necessary, and to extend rather than to reduce the length of stay. The "passport" or "voucher" could then also cover entitlements to treatment programmes for conditions which do not require hospitalisation – for example, diabetes and some cancer treatments.

Since the GPs, and the Primary Care Trusts they belong to, act as the custodian of NHS expenditure, "passports" or "vouchers" would not cover private GPs who are not part of the NHS system. However, just as it is desirable for all hospitals to be given greater management freedom as true Foundation Hospitals, it would also be appropriate for Primary Care Trusts to be given an equivalent 'Foundation' Status that allowed them to operate in the interests of their patients without excessive controls and targets from the centre. Without this freedom, there is a danger that they would remain a 'backdoor' way of an over intrusive central bureaucracy imposing controls on Hospitals. Conversely, with that freedom there are new possibilities of innovation and diversity in Primary Care Trusts opening up more choice and higher standards in primary care as well as hospital care.

9. Surely this scheme will be seen as subsidies for the rich who can afford private healthcare?

The primary beneficiaries will be those who cannot afford private healthcare – and who currently have no option but to suffer the long waiting times and often poor levels of patient care currently provided by the NHS. The aim is that they too should have greater freedom to choose where they are treated, including access to specialist treatment centres and independent hospitals at either no additional cost or a more affordable top-up than if they had to pay the full fee.

The 12% of the population who currently pay for private health insurance and/or private operations would benefit from a reduction in their costs as well. However they would only receive NHS funding if the were initiated through an NHS GP; and then

only for treatments which are authorised as part of NHS care.[12] At the most, the potential cost if all private operations claimed the payment is estimated to be no more than £2 billion and £3 billion a year – a large sum but an acceptable price to pay for introducing reforms that will provide major benefits to all.[13]

Many of those who currently pay privately are not particularly wealthy: last year, 300,000 people used their own savings to pay for a private operation, a threefold increase over the last seven years. This reflects the failure of the NHS to offer people the standard of service they expect.

If it were necessary for budgetary reasons to limit the costs initially, the tariff paid to a private hospital could be limited to a percentage of the NHS tariff, or could be reduced as the top-up rises. It could also be limited for individuals who have private healthcare cover, although this would be an undesirable discouragement to private insurance.

10. Won't it create two tier health?

No. We have a two-tier health service now – with only the well-off able to pay to access private medical care and able to avoid NHS waiting lists. Under this scheme, a wider choice of free NHS-funded care will be available to all, with the aim of shorter waiting times for all. In addition the number of people who are able to pay a bit extra for private care – for example a private room or more convenient timing and location – will be greatly expanded. So access to quality health care will be extended, and the divisions between rich and poor reduced.

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12 Current Conservative Party proposals would restrict the proportion of the NHS cost which could be taken to pay for treatment outside the NHS. This would of course reduce the cost of the scheme – but also reduce the ability of the less well off to use alternative providers.

13 See Appendix IV for details of polling evidence of the popularity with the electorate of the proposed system.

There is no question, as some have alleged, of the NHS being 'left' with the rump of difficult treatments – this is a misunderstanding of how the scheme would work. The NHS will continue to pay the costs of all those who take advantage of the scheme, whatever their condition, and wherever they are treated.

11. Isn't it a way of bringing in private health insurance?
No. There are arguments for and against having the funding for healthcare raised through general taxation as now, or through a compulsory health insurance programme – similar to that in many other European countries. However, this scheme is designed to work within the current system of state-funded healthcare.

As now, individuals would remain free to complement that with their own private health insurance if they wished to gain the additional benefits such programmes may provide. Furthermore, since an improved NHS should mean fewer calls on private services, the cost of private health coverage should fall – encouraging more people to contribute and bringing more resources into healthcare to add to the publicly funded component. However there would be a 'no quibble' guarantee that full NHS healthcare would remain available to all, free at the point of need.

12. Won't this mean a huge, costly bureaucracy?
As with schools, the intention in health is to create a system where large layers of centralised bureaucratic administration can be removed – with independent Foundation Hospitals run by local teams, and accountable more directly to their patients.

The scheme would not mean the creation of physical paper "vouchers" or payment slips. Under a 'money follows the patient' system, and with standard tariffs for each treatment, all that would be required is for hospitals to account for the number of treatments provided and to be funded accordingly.

13. Given the poor level of financial and management systems in the NHS, how can the newly-independent hospitals be expected to cope? Won't the concept be dangerously vulnerable to criticism during the transition period?

The fundamental administrative change required – the concept of 'money following the patient' – is already being put in place as part of the current Government's reforms. As from April 2005, this new system of 'payments by results' will be introduced across the NHS. According to the Government's guide,[14] it will:

- reimburse hospitals fairly for the services they deliver;
- reward efficiency and quality;
- ensure services are developed in line with local need;
- give patients more choice about where they are treated;
- allow funding to 'follow' a patient if they decide to be treated in another hospital.

These plans also introduce the concept of NHS Foundation Trusts as legally independent organisations (Public Benefit Corporations) with their own Boards. The Government claims that these Trusts will be 'set free from central Government control, manage their own budgets and be able to shape the healthcare services they provide to better reflect both local needs and priorities.' The initial round of Foundation Trusts, which start operating this year, were selected from applicants that the Government believed best demonstrated their fitness to take on these responsibilities – although in reality it relied over-heavily in the now discredited 'star' rating system. These hospitals will start operating 'payment by results' immediately rather than waiting until 2005. However, the Government plans that all NHS Trusts will have reached a standard to enable them to take on Foundation Status by 2008.

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[14] NHS, *NHS Foundation Trusts: A guide to developing governance arrangements*, 2004.

The proposals set out here do not place significant additional demands on the governance of hospitals; indeed by simplifying the proposed tiers of local community governors and board members it should make the structures much easier and less bureaucratic to manage. Additional freedoms proposed from reducing the weight of centrally driven targets will also make local management less complex – increasing the prospect of the new Trusts being able to deliver on the benefits promised. As with the current plans, the new style Foundation hospitals would be phased in over a period of years as and when individual hospitals could demonstrate that they had the management and systems to cope.

Similarly, in allowing the patient freedom to choose where to go for treatment, this scheme is simply a further liberalisation of the tentative steps proposed under the payments by results scheme described above. In particular, the freedom for the patient to use NHS funding to seek treatment at a 'private' hospital could help many existing NHS hospitals by relieving them of the pressure on their wards and operating theatres caused by long waiting lists for routine treatments.

There may be, therefore, a danger that expectations may be raised too high. However, the initial steps that have already been set in motion – while currently too limited and circumscribed to achieve their objectives – do provide a context where a more decisive shift towards liberalising local management autonomy and patient choice can be advanced without further significant disruption.

14. Does this work anywhere else, or is it just fancy theory?
Britain is the exception amongst all other major economies in having a health service entirely operated within the state sector. While there is no exact analogy to what is proposed, equally none of the other national health systems provide a perfect model that could easily be imported here. Most do, however, combine state funding with a much more diverse system of public and private hospitals and more open patient choice.

In Finland, for example, patients can choose to use state funding in hospitals in the private sector, receiving a credit of 60% of the costing the state sector. In France the individual has relatively free choice of public or private hospitals, with their social health insurance paying the bills. Around one third of all hospital beds in France are in private institutions. In Germany too, under its social healthcare model, around a third of all hospital beds are provided by private non-profit organisations and a further 14% in for-profit institutions.

Yet these countries, like most other countries across Europe, achieve higher standards of healthcare on many measures with minimal waiting lists.

15. Isn't this too risky for any political party to put to the electorate?

It is increasingly accepted (and reflected in opinion polls) that simply putting more money into the NHS as currently structured has not and will not deliver real performance improvements – or value for money. Reflecting a new mood of realism, a MORI poll recently showed that over 80% of the population does not mind who provides their healthcare so long it is good and still free at the point of delivery.

Money following the patient, and real Foundation Hospitals, go with the flow of policy development in the government as well as opposition, but represent a bold enough reform to be credible as 'making a real difference'. They can and should be presented as a way of opening up choice and quality in healthcare to every citizen – rather than the status quo where only the better off can afford to buy that option.

CHAPTER 4

CONCLUSION

CHOICE IN HEALTH AND EDUCATION is not just a theoretical construct. It is the necessary complement to reforms that remove centralised state bureaucracy from schools and hospitals, and give professionals the freedom to run the quality of services that parents and patients want. These proposals are underpinned by practical experience of how to deliver real improvements in performance. They are also equitable, bringing a level of choice to the least advantaged that only the well-off currently enjoy.

And wherever similar approaches have been tried overseas, they have proved more effective and popular.

All that is needed now is a government with the imagination and boldness to put them into practice.

APPENDIX I

COMPARISON OF PROPOSED FREEDOMS FOR SCHOOLS AND EARLIER GRANT MAINTAINED SCHOOLS

FEATURE	GM SCHOOLS (abolished following 1997 election)	PROPOSED INDEPENDENTLY –FUNDED SCHOOLS
Status	Independent, incorporated as exempt charities, holding assets in trust	Independent, operated initially by not-for profit organisations, holding assets in trust
Funding	State funding per pupil, based on enrolment; distributed direct from funding council	State funding per pupil, based on enrolment; distributed direct from funding council
Financial Freedom	Able to use and control own budget	Able to use and control own budget
	Able to raise money from sponsors	Able to raise money from sponsors
	Not able to borrow	Able to borrow within prudent limits
Freedom to expand	Limited by 'surplus places rule'; needed to apply to SOS for expansion	Unconstrained, subject to physical constraints
Freedom to recruit	Free to recruit qualified teachers and to opt out of national pay scales	Free to recruit and pay as independent schools
Freedom to set curriculum	Constrained by national curriculum	Constrained by slimmed down national curriculum
Freedom to set admissions policy	Up to 10% of admissions could be through some form of selection; greater selection required SOS approval	Initially unchanged: longer term may allow greater freedom
Freedom to exclude pupils	Complete freedom	Complete freedom
Central targets	No national targets: Governing Board sets own target	Freed from national targets: Governing Board sets own targets
Local authority involvement	No local authority control; Independent governors with no political appointees	No local authority control; Independent governors with no political appointees

APPENDIX II

COMPARISON OF PROPOSED FREEDOMS FOR EXISTING FOUNDATION TRUSTS AND PROPOSED FOUNDATION TRUSTS WITH MONEY FOLLOWING THE PATIENT

FEATURE	CURRENT FOUNDATION TRUSTS	PROPOSED FOUNDATION TRUSTS/PATIENT PASSPORTS
Status	Independent legal entities, incorporated as public benefit corporations	Independent legal entities, operated by a range of not-for profit organisations, holding assets in trust
Funding	Payment by results based on national tariffs	Payment by results based on national tariffs
	(payment follows the patient)	(payment follows the patient)
Financial Freedom	Able to use and control own budget	Able to use and control own budget
	Limited borrowing scope	Free to borrow within prudent limits
Governance	- Local members	Single Board of Directors, including professionals, managers and non-executives
	- Governors partly elected by members, but including representatives of local authorities, primary care trusts, etc	
	- Board of Directors appointed by Governors and staff	
Regulation	Authorised and monitored by an Independent Regulator; but with the Regulator having extensive powers to require and approve annual business plans that meet central NHS objectives	Authorised and monitored by an Independent Regulator; with the scope for interference and direction by the Regulator tightly limited
Freedom to evolve services	Free to innovate and develop services so long as they meet the service requirements set out in their authorisation (and the services contracted with local PCTs)	Free to innovate and develop services so long as they meet the service requirements set out in their authorisation (and the services contracted with local PCTs)
Use of patient passports to secure NHS treatment at a private hospital	Limited opportunities to have NHS treatment in a private facility where waiting times are excessive	Complete freedom to choose a private hospital at the same NHS tariff, or to top up the cost if required.

APPENDIX III

THE IMPORTANCE OF CHOICE

BARRY SCHWARTZ, an American professor of psychology, has recently expounded one view of the failure of choice.[15] He has suggested that the plethora of choices available to Western citizens have a detrimental effect on their lives, "giving rise to anxiety, unhappiness and even clinical depression".

Schwartz has called this phenomenon "choice fatigue". One example he cites is an experiment in which shoppers were found to be ten times more likely to buy jam when there were only six choices of the item on display as when there were 24. His conclusion is that consumers are presented with too many choices. As a result they cannot readily secure maximum value and end up confused and unhappy, emotions which can inhibit their purchasing.

If applied to the schools and hospitals, the work of Professor Schwartz seems to ask: why should parents and guardians, along with patients and their families, be given the unnecessary burden of having to choose which hospital or school is most appropriate for them?

Seemingly in support of Schwarz's theory, earlier this year Labour pollsters revealed that they were encountering opposition to the idea of choice, that choice was not considered the solution to the problems that exist in British healthcare and education. An article published in *The Guardian* on the 30 March suggested that Labour focus groups regarded choice as a red herring:

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15 B. Schwartz, *The Paradox of Choice*, HarperCollins, 2004.

> What people want, they are saying in the focus groups, is ready access to good public services, not more choices. They don't want a choice between this or that school or between this or that hospital. They just want a good school and a good hospital.

The opinions voiced suggest three criticisms of the scheme: Firstly, that money could be better spent improving the current systems than on abandoning them. Secondly, that the result of choice is anxiety and unhappiness (Professor Schwartz's contribution). Thirdly, that patients, pupils and parents are not expertly equipped to make the choice, and as such the purchaser is in a weaker position than the provider – and so the choice system as proposed creates an imperfect market.

However, this position is on a flawed understanding of the reasons for, and the advantages of, a choice-based system. In the first case, the system has been devised, not for the sake of choice *per se* (though many would agree, for example, that the ability to decide your child's future should not only be the preserve of the wealthy). Rather, the process of choice is intended to create a health and education market place in which competition exists to drive up standards. It does this by giving schools and hospitals the ability to spend money on those staff, facilities and services that are most relevant in their areas – something that a burdensome strategy of regulation and micro-management cannot allow for.

In the second case, the result of choice is not necessarily anxiety and unhappiness. In a YouGov poll taken between 26 and 29 March 2004, respondents were asked: "How important is it to you to have more choice over which hospital treats you and your family, and which state school children in your family attend?"

Around 65% judged it fairly or very important for hospitals and 75% for schools. Far from suggesting that choice would cause misery, the polling data would suggest that lack of choice, under the current system is more likely to lead to dissatisfaction and unhappiness for the majority of individuals in the UK.

The freedom to choose schools or hospitals would not necessarily mean that the consumers would be presented with an unmanageable number of choices. Professor Schwartz counted 6,512,000 stereo systems on the open market – clearly too many to study in order to ensure maximum value. However, it is probable that the increase in the number of potental schools or hospitals would be modest.

Thirdly, the adoption of the system will enhance the power of the parents and patients. No longer will they be the supplicant but their patronage will be sought after by the institution they are using. Nor is it reasonable to assume a perpetual ignorance on the part of those who use the services, particularly from an incrasingly consumerist society. As a result, the quality and quantity of information on schools and hospitals will grow. In the case of schools, popular league tables already exist and play a key role in the selling of independent school places; though in the public school sector they are of little interest to the prospective parent as they have little control over where their child goes. Apart from easily understandable statistical information about academic performance, other indicators of quality schooling will inevitably emerge to satisfy the needs of the consumer.

Though this is certainly not the "perfect market" the "choice" model certainly adopts many more of the advantages of the market than the current system. The result is that even if a parent is thoroughly disinterested in their child's education, the local school in which that child becomes a pupil will be better under "choice". This is because the school will be in an environment in which the head-teacher is allowed to spend his resources in the way that is best for his school, and because that school must compete for the patronage of interested parents and pupils against other schools.

In January Tony Blair said that the task for the 21st Century is to establish "public services that harness the drive of competition, and the power of choice, to the public sector ethic of altruism and equity." Choice is good, but the competitive environment created by it is better, and for improving schools and hospitals that competition is far more useful.

APPENDIX IV

DO PEOPLE WANT "CHOICE"?

SEVENTY FOUR PER CENT of voters agree that *The way we run state education is in need of a fundamental review* according to a survey conducted by ICM between 11 and 13 September 2003. In the same month, YouGov conducted a poll in which 76% of people felt that schools and education provision had not really changed or were in worse shape than when Labour came to power. In the same poll 77% of people felt that the NHS was in worse shape or not much had changed since Labour came to power.

However, in a MORI poll commissioned by the Sutton Trust carried out between 29 April and 4 May, 50% said that they would send their children to private school if they could afford to. Asked whether they agreed or disagreed with the proposal that all children should have the opportunity to go to private school regardless of their family's income at the Government's or the taxpayers expense, 47% agreed, and 30% disagreed. 46% of parents from social class AB disagree, while only 18% of parents from social class DE disagree. Those who often have the poorest access to good education were more in favour than those who do not.

When asked in another YouGov Poll held between 26 and 29 March 2004, if it was important to have more choice over which hospital treats you and your family, and which state school children in your family attend: around 65% considered it fairly or very important to have more choice regarding hospitals and around 75% of people considered it very or fairly important to have more choice regarding schools.

APPENDIX V

COMPARATIVE COSTS OF INDEPENDENT AND STATE SCHOOLS

IT IS EXTREMELY DIFFICULT to calculate precisely the amount of money spent per pupil on state education in England.[16] Government data on per pupil spending often does not include any central DfES costs, and sometimes also does not include the significant proportion of money that Local Education Authorities keep back from schools. The great majority of the cost of those services provided by central and local government to state schools need to be included in any comparison between the independent and state sector.

The following calculations are necessarily 'rough and ready' but clearly indicate that per capita state school funding is fast approaching that in the independent sector, where the average cost of day schools in 2003 was £6,150.[17]

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16 See the pioneering work by Nick Seaton in this field, *inter alia*: *School Funding: Present Chaos and Future Clarity*, CPS, 1996; *Fair Funding or Fiscal Fudge?*, CPS, 1999; and *Unfair Funding*, CPS, 2000.

17 Estimates of the average costs of independent day schools come from the *Independent Schools Management Survey 2004*, (haysmacintyre, 2004). This survey is based on the accounts of 300 schools in the independent sector and reflects the total running and capital costs of schools in the independent sector. Note that average *fees* tend to be larger than average *costs*: some independent schools base their fees on what the market will bear, rather than cost. And many set their fees high for those who can afford them, in order to generate scholarship funds to help those who cannot: 22% of all children in independent schools receive some help with fees from the school itself. Note also that since these are averages, many schools will be operating at below these costs (and some above).

1. Central and local government spending on education, England, in cash terms

£ millions	2001/2	2002/3	2003/4
Capital Spending	1,919	2,156	2,701
Current Spending	25,847	27,608	30,593
Total	**27,766**	**29,764**	**33,294**

Source: Data supplied by the DfES, based on Table 2.3 of the *DfES Departmental Report*, 2004.

Note: These data exclude spending on Higher and Further Education and spending on children and families and on skills.

Three adjustments need to be made to the table above to arrive at a figure for spending in schools in England:

- to subtract spending in England on the under-five Sure Start programme;
- to include spending on teacher's pensions in England;
- and to include a proportion of overall DfES central administration costs in England.

2. Total central and local government spending on schools, England, in cash terms

£ millions	2001/2	2002/3	2003/4
Total	27,766	29,764	33,294
Minus Sure Start	374	544	541
Plus Pensions	5,349	5,551	5,194
Plus central admin	880	1,087	1,227
Total spending	**33,621**	**35,858**	**39,174**

Source: Data supplied by the DfES, based on Table 2.3 of the *DfES Departmental Report*, 2004; and Annex A of the same report.

Note: Data for Sure Start, teachers pensions are only available for the UK. To arrive at an estimate of these costs for *England*, total *UK* costs have been reduced by 20%. Pensions costs fall in 2003/4 as a result of a definitional change.

Data for central administration, inspection costs and miscellaneous services are available for England, but include the costs of Higher and Further Education etc. To estimate a figure for schools, the England costs have been reduced by 25%.

3. Forecast of spending on schools, England, in cash terms

The following table assumes that spending on schools in England will increase at the same rate as the increase in overall DfES and Local Authority expenditure in England.

£ millions	2003/4	2004/5	2005/6	2006/7	2007/8
Total spending increase		+7.1%	+11.4%	+6.3%	+6.4%
School expenditure	39,174	41,955	46,738	49,683	52,863

Source: Estimates of the total spending increases are derived from *Spending Review 2002* table 6.1 for 2003/04 and 2004/5, and following years from the 2004 Budget Red Book.

4. Pupil numbers in maintained schools in England and calculations of spending per head

	2003/4	2004/5	2005/6	2006/7	2007/8
Pupil numbers (000s)	7,461	7,405	7,323	7,250	7,177
School expenditure (£m)	39,174	41,955	46,738	49,683	52,863
Spending per pupil	**£5,250**	**£5,666**	**£6,382**	**£6,853**	**£7,366**

Source: Data for pupil numbers in maintained schools are from http://www.dfes.gov.uk/trends with the exception of data for 2006/7 and 2007/8 which are extrapolated on the assumption that pupil rolls continue to fall by an average of 1.0% p.a.

Note: Data for pupil numbers are full time equivalents at January of that year and include sixth formers.

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