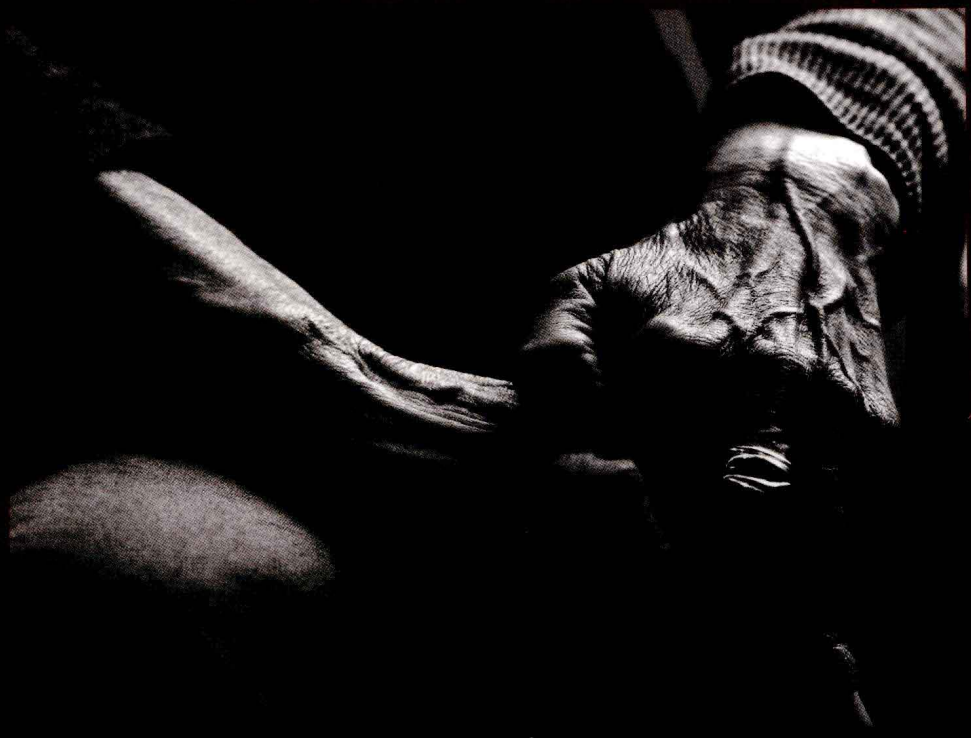
BROADENING PERSPECTIVES ON SOCIAL POLICY

CHOICE

CHALLENGES AND PERSPECTIVES FOR THE EUROPEAN WELFARE STATES



Edited by

Bent Greve

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Editorial Introduction

Bent Greve

'Choice, choice and more choice' has been a buzzword in many welfare states around Europe in recent years. This has transformed the welfare states in the direction of a more market-oriented approach, changed users into consumers and increased the emphasis on private providers. Expectation of higher responsiveness from the provider has been part of the reasons for change. Delivery of welfare services has in many countries seen a split between who finances and who provides. Furthermore, the starting point for this development has been the constant focus on increased effectiveness of the public sector in all types of welfare states. The boundary between the public and private sectors is consequently less distinct than it used to be.

More choice has been linked to an increase in competition between welfare providers, including also areas with public delivery only, ensuring intra-organizational competition. Competition has been introduced in various ways, including the application of per-user funding, vouchers and tax credits. However, the establishment of free choice has rarely been associated with an analysis of the consequences of introducing choice.

These consequences relate to whether free choice in fact increases competitiveness, improves efficiency, changes user empowerment or has an impact on equality of access to central welfare services. Neglected in the analysis has thus often been the possibly negative impact of choice, including the potential increase in stress when people are obliged to choose. Questions about whether transaction costs have increased more than any possible efficiency gain have received more scant attention.

This book describes and analyses recent change with regard to free choice from a theoretical and empirical perspective. Theoretically, this is done by discussing conditions for choice and, especially, the Third Way understanding of the impact of choice. Empirically, it is done by concrete analysis of a variety of choices in the welfare states in Europe, and also of specific sectors (such as education, health, day care and long-term care) in the welfare states, including choice of provider and type of services. Gender implications and the impact of choice are also central to several chapters in this book.

The combination of theoretical and empirical articles, within different spheres of the welfare states, informs us about core changes in the welfare states including the actual use of choice, and why choice is used or not used. Empirical analysis is needed because equality, for example, cannot only be understood and measured with regard to economic parameters. Analysis is needed also to study equality of access and the possibility of using choice, including the possibility of having an informed free choice. The relationship to the New Public Management and change in the public sector has also been central for several of the chapters.

The book starts with a chapter by Bent Greve setting the scene for what type of conditions need to be fulfilled in order to ensure an informed choice for users, without negative impact on equality, especially in access to services. One of the conclusions of the chapter is that, although certain conditions that need to be fulfilled can be presented, empirical analysis – sector by sector, provision by provision – is necessary in order to ascertain the precise impact on equality, efficiency and cost related to free choice.

Julian Le Grand has been one of the proponents of the expansion of choice in Third Way politics in the UK. He was also among the first to analyse the conditions that must be fulfilled in a quasi-market in order to ensure a properly functioning choice system. In the chapter by Ian Greener and Martin Powell, Le Grand's earlier and later writings in relation to choice and quasi-markets are explored. This chapter thus at the same time provides a strong overview of one of UK's leading social policy analysts, and also reflects upon why changes in the original positions of Le Grand, especially from 1992 to 2007, have taken place. Le Grand's historical worry concerning equality of access and the functioning of welfare markets has presumably changed towards an understanding that competition in itself within the public sector 'serves the public interest better than trusting professionals'. Greener and Powell thus argue that focus seemingly has changed from the critique of market-based reform to one of public sector delivery.

One of the sectors where choice has been expanded in several countries is education. In the UK, voice is now seen as central for the user's ability to influence the educational sector, as Deborah Wilson argues in her chapter. The analysis is carried out by going back to Hirschman's original work on exit, voice and loyalty, which is then applied to the English educational sector. In this way the chapter shows how to interpret and use classical understanding in a modern context. The chapter argues that, although voice and choice should be able to complement each other, this has not been the case in the UK, or at least only for a limited number of users. The meaning of quality in the service can also be understood differently, and thus the risk is that those more able to express their views might be more readily listened to by producers. This will implicitly and avoidably imply a new kind of inequality in the welfare states.

What choice is and when choice is not really a choice is, with a focus on Germany, the central core of the chapter by Florian Blank. The chapter offers a precise and clear overview of recent reform, especially from an institutional perspective. The chapter also argues that, although choice has not been at the forefront of the debate, it has gradually been introduced. Differences in

the ways choice works are related to how closely it resembles the market's way of working, whether it is voluntary or obligatory, and the range of choices open to users. Quality of choice is also influenced by these institutional frames, which also include the way resources are calculated and distributed within the different spheres of social policies.

We move from Germany to Italy, where Paolo Graziano raises the question of whether recent reforms in the Italian welfare state have increased real choice for citizens. Thus, for example, the change in the pension system implies that the gross replacement rate will decline significantly, especially for those not using the option of saving in a supplementary occupational pension system. The option for choice might thus be an option for a lower pension and, thereby, imply new inequalities in the welfare states. Opportunity and choice might therefore be possible only for a more limited group in society.

The impact of choice is also the focus of the next chapter, by Melanie Eichler and Birgit Pfau-Effinger, who ask the question why, despite more choice in care for elderly people in Germany, it is still the case that the majority of those needing care are looked after by family members. Cultural values embedded in who has the responsibilities in the families, it is argued, are the main basis for this. Family care is perceived by the users as the best-quality care, making choice or use of choice a less relevant issue. This is documented by qualitative analysis using 33 interviews with women carrying out care for families in the years 2004 and 2005. The chapter thus highlights that choice in itself is not sufficient to change attitudes and behaviour, and that this also should be taken into consideration when implementing choice. Furthermore, trust and good personal relations can be highly important, especially with regard to care.

A comparative analysis of the impact of choice, especially for people with disabilities, when moving towards cash-for-care is analysed by Kirstein Rummery. The chapter includes a comparison between the UK, the Netherlands, France, Italy, Austria and the USA. A clear conclusion is that market solutions can offer positive effects for both users and carers if the state continues to have a strong impact and influence on the programmes, at the same time providing users and providers with the possibility of exercising choice and control. If, on the other hand, this does not happen, there will be a negative impact on gender equality, and certain users might have difficulties. Cash-for-care seems to be especially suited to the young and better-educated. This points to the dilemma between the possible negative impact on social division and the empowerment of some users.

The risk for individuals when choice systems offer exit options from previously mandatory programmes is analysed in the chapter by Menno Fenger. The possible consequences in relation to adverse selection are examined in relation to welfare policies in four European countries: the Netherlands, Spain, Sweden and the UK. The impact of opting out is different in each of these areas. Pensions are a case where opt-out has been prominent, but despite this no clear pattern of adverse selection has been observed. Still, opting out has only been introduced in a more limited way in recent years in the four countries, and might in the years to come be a consequence of more choice in welfare states around Europe.

Choice and the freedom to choose lifestyle are analysed through a study by Steven Saxonberg of how the promotion of gender equality might have an impact on choice in families. Differences in family policy, including access to day care and parental leave, have an impact on the choices families can make. The more gender-neutral Nordic welfare states have been better able to pursue real freedom of choice in daily life. Welfare services can thus influence the possibility of having a real free choice within the family and between men and women in the welfare states.

The chapter taken together point towards remarkable change in welfare states in Europe – changes that imply new dividing lines caused by the use of markets and marketization as a consequence of more choice, but also implying that those not able to make choices in an informed way run the risk of less-good service. Inequalities in income or occupation could thus be expanded to be inequalities in the ability to manage choice. The risk is that social cohesion will be reduced given that, for some, choice is an option and has a positive impact. For others, more choice is less and might imply social exclusion.

Choice can therefore have positive empowerment elements for the users. However, the risk observed in several European countries has been profound, for example, in that it implies new dividing lines of inequality and that choice is not possible for all. In particular, the ability to make an informed choice based upon clear and systematic information is far from the case for everybody. An eye on the possible negative impact of increasing choice, due to market failure, is thus still essential.

1
Can Choice in Welfare States Be Equitable?

Bent Greve

Introduction

Choice and increased choice have been at the core of the debates and changes in welfare states in Europe. This development has been observed across traditional understandings of welfare regimes. Increase in choice has not only been seen in liberal models with an already high emphasis on markets and marketization of welfare issues, but the choice revolution has arrived also in universal welfare states such as Sweden and Denmark (Blomqvist 2004). Choice is shifting the consumer from a passive recipient to an active choice-maker (Mann 2005). Choice is thus at the outset a good thing, as Appleby *et al.* have expressed it: 'who could argue against the desirability of allowing patients more say in decisions concerning them' (2003: 2). Choice has increasingly been on the agenda, partly because electorates are increasingly willing to choose private alternatives, including in the health and pensions areas (Ross 2000). However, the question is: Will more choice in all welfare sectors and in any conditions be positive for societal development? Furthermore, it might be the case that more choice in fact is less choice (Schwartz 2004).

'Positive for societal development' will be understood as related to a higher or at least a stable degree of equity in access to welfare services. The analysis of this depends on how one looks at equity and what the outcomes are. It might be considered that expanding choice is about enhancing equity and opportunity (Le Grand 2007). It has also been argued that 'choice and control that is facilitated as an outcome of social care ... has the most significant impact on experiences of independence, well-being and social inclusion' (Glendinning 2008: 461). The counter-argument is that it is of no use to have a choice if, for reasons that will be described later, it is not possible to use it, or the real option of choice is there only for some users, and also that choice understood in this way can be highly individualistic.

Choice could also be 'positive for societal development' if it implied a more efficient delivery. This will, although a more limited consideration, also be discussed (cf., for example, the section on transaction costs, below).

The focus in this chapter is on conditions that must be fulfilled in order to ensure a free and well-informed choice, but also on the impact on equity under different conditions for choice. Equity is understood as equality in the ability to exercise choice and gain access to welfare state services. Access is further understood not only as a formal right to access; there is also a requirement that informal barriers (such as the possible cost of using the right to choose – for example, transport costs and other transaction costs) are not a hindrance for an individual exercising choice. For some it is not the cost, but the difficulty in travelling which can be a hindrance (Exworth and Peckham 2006). Equity can also be achieved when increased choice reduces waiting lists and thus presumably makes access to service more equitable. This has, for example, been shown to be the case in one analysis from the UK (Dawson *et al.* 2004). Equity, it has been argued, is a reason for choice (Le Grand 2006), but it is also differently distributed dependent on class and income (Giddens 1998b).

Choice has been argued to be possible in principle in all sectors and all welfare areas. Markets or market mechanisms have been seen as the core ability to ensure a proper balance between demand and supply, and the best method to ensure correct revelation of the citizen's preferences. Disorganization of care has been observed in this process (Bode 2007). With regard to welfare state goods, the centre of attention has especially been on the right to choose between different types of service and service-providers. However, choice in relation to income transfers such as pensions has also been an area of growing interest in relation to both the type of pension scheme and its components. Choice seemingly has its root in neo-liberal reform strategies (Fotaki 2007), but has also been in line with strategies on empowerment. Choice has further been introduced without any evidence that this would make the welfare state more effective (Thomson and Mossialos 2006).

Choice in the welfare state can therefore be understood from various and very diverse perspectives. It ranges from neo-liberal, to empowerment of the vulnerable, to third way politics. Thus, for example, 'the third way politics in the UK was an extension of the market, but also creation of quasi-markets in the public sector and a choice of suppliers in education, health and social care' (Jordan 2005). This was put extremely clearly by Tony Blair in 2004: 'Choice puts the levers in the hands of the parents and patients so that they as citizens and consumers can be a driving force for improvement in their public services' (Tony Blair, *Guardian*, 24 June 2004). Further, it has been argued that people are consumers only in the market domain; in the public domain they are citizens (Le Grand 2007). The choice agenda thus had the ambition to 'reconcile the social democratic conception of a free, universal health service with a range of modernising strategies that draw on private sector investment and resources' (Newman and Vidler 2006: 103). The logic is, in general, that citizens would like to have the same kind of choice in the NHS and other welfare areas as in the market, but perhaps without a clear understanding that the private sector might also have problems with delivery.

Choice in delivery of services can also be understood as part of reflexive modernity (Beck 1992). Giddens has pointed out that there is a need to find a new balance between individual and collective responsibilities (Giddens

1998a). As part of the move towards choice, there is a drive to empower consumers and ensure they have a louder voice (Clarke 2005).

Public choice theory has, as another approach, pointed out that increase in individual choice is important so that delivery can be made in the way the user wants it, and not how the bureaucracy would like it (Mueller 2003). In addition, the New Public Management tradition has pointed to choice as part of the process of increasing efficiency by the pressure it can place on providers. Part of this reflects Tiebout's original description of voting with the feet as a possible part of the choice revolution, and an alternative to democracy (Cullis and Jones 1998).

However, choice is not something which just takes place freely and out of context, as the following indicates:

> By getting children to harvest, prepare and cook healthy meals, he managed to get them to eat food they would not previously even taste ... [the argument further being that children's choice was used] as the excuse for providing unhealthy junk meals. Children's preferences were culturally determined; by changing the context, he changed the choices. (Jordan 2005: 438)

This is an example of a wider societal impact and shows that the conditions and context for choice have an impact on what type of choice is made, and how. Therefore, choice is not only something left for the market to have a say in, but can also be influenced by other actors, e.g. both civil society and the state. This is not only about choice, in itself and between providers, but also about the way systems are developing, and about ensuring the possibility for different individuals to make an informed choice. When moving from a perspective that is not focused only on the way the market works, but also on the impact on equity and on society, new perspectives for the impact of choice open up. This is further relevant, as the whole issue of choice has been developed by the impact on welfare delivery, and as a consequence of that 'business jargon capturing both welfare bureaucracies and non-statutory agencies involved in service provision' (Bode 2006: 346).

Furthermore, the way choice is made can be based upon types of heuristic. Availability heuristic is the influence of choice based on latest occasions, for example, how easy it was to get in contact, or get an appointment, the length of waiting time, etc. Representative heuristic focuses on our making choices based upon our preconceptions or stereotypes of a given situation, for example, how we expect primary education to be (Fotaki *et al.* 2005).

Social changes and individualism are seemingly moving societies towards a consumer culture with regard also to welfare state issues, but in this context the choice can be both informed and manipulated. Regulation of supply has been part of policies in relation to, for example, drugs, alcohol and gambling. To put it another way, the free choice does not take place in a free and open market because society has decided to restrict choice in these areas. This further reflects the fact that restrictions on choice can be necessary as part of the optimization of societal welfare, here especially understood as equality in access to welfare service.

Finally, increased choice can for some people be a reason for a lower perceived living standard, as they might feel frustrated and stressed by having to make choices, and also by having the risk of making the wrong choice, which can have an impact on their daily life. For the individual a wrong choice regarding a new pair of trousers is irritating, but a wrong choice in saving for a pension can reduce one's economic security in old age (Schwartz 2004). The dire consequences for living standards in the future of making the wrong choice now can thus be a specific new type of risk in welfare states. This might happen despite full information in principle having been given, as not all people have the ability to use such information well in decision-making. Non-decision therefore often also becomes an option that many people take, as they believe that the implicit choice that others have made for them is the best one. The way choice is presented might thus have a huge impact on the final outcome.

Choice and choice in welfare states have many different aspects, and the variety can be understood as being in relation to:

- content of service (specification of inputs or outputs);
- level (quantity, perhaps subject to a charge above a certain threshold);
- identity of a gatekeeper (case manager, commissioners);
- provider. (6, 2003)

The rest of this chapter will focus on what conditions should be fulfilled in order to ensure a free and informed choice. At the same time it will focus on the impact on equity, including when equity and choice are on a divergent, and where on a convergent, path.

In general, six conditions should be fulfilled in order to ensure free choice without negative impact on equity (Greve 2003):

1. competitive market forces
2. sufficient and precise information
3. low transaction costs
4. precise incentive structure
5. avoidance of incentives to cream-skimming
6. trust in providers

The analysis in the following sections will revolve around these six conditions. In line with Hirschman (1970) one could also have focused on exit, voice and loyalty as possible options in a choice-based system. The question would then be: when and for whom especially is exit an option? Whether one can or cannot use Hirschman's three options is also part of the equity question. The possibility of using choice also to exit is therefore part of the conditions to be fulfilled if choice is not to imply a negative impact on user access to different types of welfare services.

Can a Competitive Market Be Ensured in Welfare Delivery?

Traditional economic analysis points to the importance of the need to have many buyers and many suppliers in order to ensure a competitive market.

Full information is also important; this will be returned to later. The question is thus: Is it possible to have many buyers and sellers in a welfare market?

Presumably, the answer will depend on the more specific aspect of the individual welfare product to be delivered, but also on many of the service aspects of the welfare market, including the difficulty of measuring and ensuring quality of the service over a long time. A more detailed knowledge of each individual area needs to be analysed, and it is not possible theoretically to find a final answer for all types of welfare services. Sometimes, it might take time to develop a market. This has, for instance, been the case in Denmark, where the number of people using a private provider of practical home help for elderly persons has risen from 17,054 (out of 166,371 eligible people) in 2004 to 39,507 (out of 141,568) in 2007. The private welfare sector has thus been rapidly expanding in this area. However, it has to be borne in mind that this is a sector with low demand for intensive capital investment to start up a company.

Specifically, the more care-oriented aspects of welfare delivery can be difficult to disentangle from the classical industrial product, where quality might be more easily measured. Care can, further, be very individual, and a common measure for both quality and quantity might not be so simple to find. Therefore, choice with regard to care, and the public sector's ability to ensure good-quality care, even when delivered by private providers, will be a new challenge. The vulnerable elderly in need of personal care will, for example, be in need of treatment even on the days when a private provider does not function. Furthermore, the public sector will have to ensure that monopolies are not also developed by private providers, given the risk of higher prices and/or lower quality if this happens.

The regulatory function in the public sector will thus need to be increased if marketization and the use of quasi-markets is increased, as has been the case when expanding choice in the welfare states. The regulator will further need to be aware not only of the cost aspect of the delivery, but also of the quality aspect and ensure that weaker groups also have access to high-quality services. The level of increased cost in relation to this depends on the degree of internal control in the public administration already established.

A competitive market, as argued in classical economic textbooks, is the most efficient way to deliver service, as this reflects the choice of individuals, and the choice in itself points to what the users want. However, even if the market is more effective in delivery of certain goods and services, the extra administrative burden can reduce societal gains by moving delivery from state to market (cf. the section on transaction costs, below).

A specific problem relates to the transformation from users to consumers. Consumerism changes the role of the individual, but the mixed economy might also have 'lost these qualities of fairness and responsibility' (Baldock 2003: 68). When one is a consumer and not a user, the right to complain and demand individual solutions increases. Part of the choice revolution, on the other hand, exactly reflects the wish to move away from a monopoly public provider to a more responsive provision of goods and services.

An ethical issue also arises as to the way to ensure the protection of those vulnerable people who might be 'misused' by being provided with a lower

quality of service than is reasonable, or than perhaps has been paid for by the individual or the public. It is thus important to establish methods of reducing cream-skimming, and this can be difficult (cf. below).

Even if there are problems related to creating a market, an argument in favour of choice has been that 'it reduces the role of the middle-class voice in allocating health resources' (Le Grand 2006: 704). It is, however, difficult to measure this, as the ability of the middle class to press for higher levels of spending is often balanced by tight management of welfare spending, and in recent years developments in spending, including in the area of health care, do not support the thesis.[1]

Still, the balance between empowerment and the ability to act and use freedom as consumers, given extended choice, is important. Will the weaker groups, by being in a better economic position, also be in a stronger position *vis-à-vis* providers, or do other aspects also have an impact on the possibility of exercising choice, such as educational attainment level. This again needs to be empirically analysed from case to case, from country to country, and also from the varieties of different types of context.

Finally, if a competitive market can be ensured in relation to choice, this implies that a producer who has not been chosen must expect to leave the market. This implies that the choices of other users can have a negative impact on those who preferred this producer, as they will have to find another producer, and this might well turn out to be one they already know that they do not prefer or have less trust in. The possibility that a provider might be forced out of the market also implies a need for the public sector, at least in certain welfare areas, such as care for the elderly, to have a 'back-up'. It also implies a need for a regulatory function to ensure that the contract is fulfilled, and its quality.

Sufficient and Precise Information

A competitive market can only function if there is full and precise information easily accessible for all users. Information can be costly for providers to make available and this will increase the price of the products. Not all users will be able to understand information in every field where they have the option to make a choice. All providers might not be prepared, for a variety of reasons, to provide the information or at least the necessary and correct information, and if they do provide it some will charge for it. Information, and the ability to understand and make decisions based upon information, can thus be a reason for increased inequity in a choice welfare system.

Asymmetrical information can further increase the risk of that those less informed will lose out. This is not the case only in very complicated areas such as pensions, but can also be the case for more 'ordinary' types of care. One would need information on the relative quality of providers, and one should also be aware that 'exercising choice does not necessarily need a lot of knowledge, but informed choice does' (Appleby *et al.* 2003: 24).

Even if information is available, it might be the case that the amount of information makes it difficult for some to make the choice. This can, as an

example from the financial sector, be due to the fact that 'participants with limited financial experience are demotivated to make an individual selection when being confronted with a bewildering range of over 600 alternatives' (Hinrichs 2004: 44).

Providing information in areas where consumers do not have the necessary background to make an informed choice might thus be very difficult. This can be shown by the fact that when people are offered choice, but at the same time are told that if they do not choose they will be given a specific option, then most people in fact do not make a choice, but instead implicitly choose the package decided by the supplier. Overstating or understating the impact of choice can also have an effect. This is, for example, the case in the health-care sector, as 'risk information can also be subject to manipulation to produce different decisions or interpretations by the patient' (Fotaki *et al.* 2005: 16).

Deciding not to make a choice will thus also have an impact, and, if the information is presented in such a way that it points towards specific types of choice, this will be the outcome. Non-decision might thus be the most common choice, and so no real choice has been enabled. It could be important to take into consideration the complexities of the area in question before embarking upon the development of increased choice in welfare states. The very complex decisions, for example about the use of different types of medicine, should therefore be taken by a specialist.

Low Transaction Costs

The cost involved in increasing choice in welfare delivery is an important aspect of the choice agenda. Change in cost can be a consequence of increased choice for both providers and users, and thus also for society as a whole.

The increase in cost relates to, at the least, the following elements: information, control, excessive supply, increased transport, time to implement choice, a new type of administration. The new type of cost arises because, when welfare services were delivered by the public sector, a clearer link existed between provider and users, whereas in a choice model, and especially when private providers are included, an extra link has to be included. This is needed in order to ensure that persons have the right to the service, but also that quality and price for the service are well known to all. Furthermore, the provider needs to know what it will receive in income, the criteria for receiving payment and the incentives it will have in the way the choice is organized.

If there are user charges, this will imply three different but interlinked set of prices for producer, public sector and user which all in their way can have an impact on who can make choices and the total level of societal cost of the provision of the service. The making of contracts will therefore also be more important than it presumably has been in the classical provision of welfare. Finally, there might be administrative costs related to handling user charges.

This is not the place to go into details about cost and its calculation. The intention has been to point out that it is an issue which can have an impact on equity. It can, however, be argued that, even though increased cost can

be the consequence of choice, this has to be compared to increased efficiency and the consumer surplus created by having choice.

The list of extra costs above does not include the possible psychological stress factors arising from choice (Schwartz 2004), but, theoretically, one should include these, as for some they can be a problem. Making a choice implies the risk of making a wrong choice, which can, for example, have a devastating impact in the area of pensions. On the other hand, if choice increases well-being then this can be a reason for expanding choice (Jordan 2006).

Still, from an equity point of view it is important that the cost of making the choice is not prohibitive for the individual. For example, 'if no or little help with transport costs is offered, then inequalities in utilization are likely to be exacerbated by patient choice' (Le Grand 2006: 703). From a societal point of view, the total transaction cost of more choice should also be measured against the benefits achieved by a given choice, as the transaction cost could have been used instead to deliver welfare.

Precise Motivational Structure

As welfare services are not the same as many private goods, and as it is important for societies to have several of these services (for example, health care), then even if it is not compatible with market delivery, there is a need to ensure that a clear motivational structure for suppliers is in place. Different types of incentive structure are at play ranging from a fee per user, types of capitation fees, bottom or top income limits, etc. What works in one area might in fact not work in other areas, given the differences in number of users, sunk costs related to the area, quality requirements, etc. There is also a need to ensure that the producers have incentives to treat all clients.

Furthermore, this is an area where the classical problem with regard to principal/agent is in place (Rees 1985). That is to say, in relation to choice, the agent does not reveal all knowledge to the principal, in order to be in the best possible position. The relation between principal and agent is in many ways the same in principle whether we are talking about a public or private provider, but the possibilities for internal control are higher when delivery is inside a public organization compared to how it is with regard to private providers. This increases the need for specified contracts and agreements if using private providers (cf. the section on transaction costs, above).

This is not to say that motivation cannot be achieved, but it increases the complexity in the relation between decision-makers and providers of different kinds of services. Another issue with regard to the principal–agent relationship is the risk of cream-skimming (cf. the next section).

Incentives to Cream-skimming Are Avoided

A provider will have the incentive to cream-skim as this puts the provider in the best situation.[2] In a free-choice system the risk is that the provider will, if it can or is allowed to, pick the best lemon (Akerlof 1970). This might make

it more difficult for persons who are in need of complicated treatment or care to access this. If the more 'difficult' cases are not skimmed away by providers, another risk is that providers use cream-skimping, i.e. reducing the quality of the treatment for the individual patient (Propper *et al.* 2006). Therefore, an important prerequisite for the functioning of a proper system is that the right incentives for providers are in place (cf. also the section on motivational structures, above). This can be the right price, conditions for receiving users etc.

In the health-care sector, methods to avoid cream-skimming can, for example, be:

1. stop-loss insurance, e.g. if a patient is very expensive, more resources will be given;
2. users have no choice, and the provider will have to take all patients referred to them;
3. risk-adjust the pricing system (but this is a complex and difficult measure);
4. tariff for treatment inversely with a deprivation index. (Le Grand 2006)

None of these is simple to implement, and they can have a negative impact on other aspects. For example, even a simple suggestion that the provider will have to take all patients referred to them might imply longer waiting lists, or that the treatment will be less thorough than otherwise.

It seems possible, though not simple, to find systems in the different areas of the welfare state to help in ensuring that cream-skimming is, if not avoided, then reduced (Barros 2003). Still, choice raises new issues in relation to the steering of the welfare state if the idea is to ensure access for all.

Trust

This section will, albeit briefly, look into trust as an element in guaranteeing that the outcome of choice from both society and individual users' point of view can be considered as useful. The analysis will not deal with how trust can be understood as a concept (cf. Sztompka 1999), and the possible relation between social capital and trust will not be included.

Trust in delivery will be an important condition for having a functioning choice system if the cost of the system is to be reduced, as trust would reduce the need for detailed control systems. Trust has been seen as an element that could reduce uncertainty and thereby increase efficiency (Bartlett *et al.* 1998). A core issue is that 'if individual choices and spontaneously created bonds cannot be relied upon to create stable institutions, let alone sustainable and just ones, what kinds of social units, of what size, based on which values, should be nurtured, and by which policies?' (Jordan 2005: 428).

Trust is therefore an important aspect in ensuring that, on the one hand, choice can be effective and, on the other hand, that misuse of the individual does not take place, for example, that more vulnerable people or those less familiar with making choices get what they have a right to and that it is of sufficiently high quality.

Trust is not only trust in delivery; if users have a 'lack of understandable and trusted information, [they] do not engage with the choice they have, and as a consequence, make no choice at all' (Mann 2005: 82).

Trust can be established, trust can be destroyed and trust can be misused. This implies that ensuring trust is not something one can just do and then expect that the trust will remain in the future. Misuse of trust happens when a supplier, for example in relation to care, first establishes a trustworthy position, and then reduces the quality when it has become difficult for the consumer to change supplier. Given that many choices in fact are based upon non-decisions, then trust in those providing the information on which the choice is made is extremely important. Therefore, information should not be left to the providers of the services, but should be based upon a common concept and be under public control.

Equity

The issue of equity has been running through the sections above, so this section is intended mainly to sum up and be more specific in relation to the interaction between choice and equity.

It has been argued that if policy-makers are concerned about equitable distributional outcomes – avoiding adverse selection and segregation – 'then they must be prepared to spend large sums, for none of the design solutions are cheap' (6, 2003: 265). This implies that if it can be indicated from the outset of an analysis that the expected outcome of a choice programme might have negative impact on equity in a society, then it is in fact the concrete specification and implementation of the programme that are important when trying to judge the impact on equity.

Nevertheless, the ability to make informed choices can be a very different thing, depending on, among other things, the social capital of the individual, but also on elements such as transport costs. Therefore, especially in the area of education and health care, inequalities seemingly arise (Greve 2002).

In the area of health care the inequalities can arise for several reasons: lack of ability to communicate, lack of ability to pay, but also differences in access to specialists in a continuously specializing health-care system – as Appleby *et al.* have expressed it: 'Choice is not a free good' (2003: 35). A specific problem to address is that if the choice results in a less positive outcome, how then should this situation be redressed (Glendinning 2008). In some areas choices are one-off, in others they can more easily be changed (meals on wheels, home-help, community care, etc.) (Bailey 2006).

Inequalities arising from choice can vary also among countries, given their geographical situation and the way a market-like system has developed. Therefore, it might be, as in Germany and France, that 'abolishing choice and making health insurance compulsory for the whole population is the most effective means of dealing with adverse selection – a conclusion which governments in both countries have recently reached' (Thomson and Mossialos 2006: 324).

This also implies that if 'public expenditure for the provision of social services significantly narrows income inequality' (Marical *et al.* 2006: 4), and