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PUBLIC SERVICES

Radical changes in the NHS

From 'doctor said' to 'patient-led': 60 years in the life of the National Health Service

Helen Coleman, ESRC research broker for public services

THE NATIONAL HEALTH Service's 60th year will be marked not only by a celebration of the past, but by radical and far reaching plans for the future. Gordon Brown has said he wants the NHS to be clinically led, 'patient-centred' and responsive to patient needs: rising expectations and new technology make now the time to look ahead. The prime minister has invited health minister and leading surgeon, Lord Darzi, to conduct a comprehensive review. He will deliver his final recommendations in time for the NHS's 60th anniversary in July 2008.

Lord Darzi will seek to establish a vision for the next decade with the help of patients, doctors, nurses and other practitioners. We can expect this to be based less on central direction and top-down targets and more on patient control, staff empowerment and local accountability. Fewer accident and emergency departments, downgraded district hospitals and regional specialist super centres balanced by beefed up community services are all possibilities. Ministers say the review will be 'unprecedented' and 'the first of its kind'. But in truth, it's a mere 18 months since the last 'unprecedented' review – *Our Health, Our Care, Our Say* – which promised a 'new direction' that would be sustained.

The NHS is our most important public service.

Arguably, the NHS is our most important public service, and certainly any government – and any prime minister – would want to be the one that gets it right. This could mean a perpetual cycle of review and reform as the health service is blown by the winds of political change. Or it could be the perfect way to learn and improve, as the reformers try a range of techniques and tools, all under the watchful eye of social scientists. One thing is for sure: if there is a policy change or new regime, there is a researcher not far behind, measuring its success, observing its impact and providing a critique, their work often outliving the policy. And there's much for Lord Darzi and his colleagues to learn from this objective and impartial research, to ensure that their vision for the future builds on the strengths of the past 60 years, without repeating the mistakes.

Social scientists, many funded by the ESRC, have examined the full range of NHS reforms, from increasing patient choice and creating competition between providers to setting demanding targets and incentivising staff. Each approach has its strengths and weaknesses – there is no single solution – but there are lessons to be learned from them all.

Policy development

Research by Dr Ian Greener of Manchester Business School, under the Cultures of Consumption Programme, has traced the development of NHS policies over the last 60 years and found that some of the so-called 'new ideas' are anything but new. Analysing NHS policy documents from its inception in 1944, Dr Greener finds that, far from being a new idea for the new millennium, choice has entered the policy landscape incrementally over the last 30 years. Certainly, at the outset a patient's choice was limited to a choice of GP alone, but since the 1970s, there

Perhaps the greatest dilemma facing the NHS today is the conflict between our rights as health service consumers and our responsibilities for our own health.

The idea that public service users should be treated as consumers is picked up in research by Professor John Clarke of the Open University. He argues that the health service places a strong emphasis on developing 'expert patients', who will know about and take responsibility for their own conditions and can make informed choices. But he points to the potential fault lines in this approach around the question of 'who knows best', where professional judgment meets lay expertise and a stronger service user voice. Choice for the consumer may be uncomfortable for the provider and indeed may interfere with the clinical exchange. Behind the principle of granting choice to NHS customers is the idea that doing so will drive greater productivity and higher quality from health service suppliers, as they compete for the business of the sick.

This idea is tested by Professor Martin Gaynor of Carnegie-Mellon University in a study published by the Centre for Market and Public Organisation. He reviews the privatised healthcare market in the United States, showing that competition means higher quality for consumers only where prices are regulated. If service providers are allowed to compete on price, as well as quality, the outcome is much less certain. Market-oriented public service reform should proceed with caution.

A common thread of many NHS reforms over the years has been the drive to become more business-like and efficient. And what better to focus the mind than significant financial incentives, where priority conditions are linked with targets and rewards? Research by Professor Bruce Guthrie of the Public Services Programme examines how the culture of general practice is changing as GPs respond to the new 'quality and outcomes framework'. Does the quality of care for these

A common thread of many NHS reforms over the years has been the drive to become more business-like and efficient

has been a growing discourse of responsiveness, as services were decentralised to make them more readily accountable.

After a pause in the early Thatcher years, from 1989, patient choice again gained ground, to address what was seen as a black hole in NHS funding. But this time, choice was managed by an intermediary: health professionals made the choices, while direct powers for patients remained limited. When New Labour came to power in 1997, policy required that health practitioners respond to patient 'wishes' as well as their needs, as patients were granted the control to make their own choices. It is with such gradual changes that NHS users have developed from being patients, with the power to determine their own care limited to a choice of GP; through being customers, with some rights and recourse, but most information and therefore choice mediated by practitioners; to consumers, whose rights, power and agency are more thoroughly recognised.





► priority conditions increase at the expense of others? And what of 'holistic' health in this new, condition-specific regime?

The research finds that business incentives alter general practice philosophy and, though the long-term effect of these changes is uncertain, three of the four practices studied have already developed an increased focus on the surgery as a business. Professor Guthrie believes this shift could conflict with traditional philosophies of personal, holistic care for individuals, and comprehensive care for populations. Although care defined by the new framework accounts for only 15 per cent of general practice work, the financial imperative prioritises incentivised health conditions, sometimes at the expense of lower-profile areas of health, such as depression. There is also a clash between a holistic approach to general practice – caring for the whole person, not just their disease – and the condition-specific emphasis of the monitoring system.

For Professor Peter Taylor-Gooby, Director of the Social Context and Response to Risk Network, it's not just the NHS culture of care that's threatened by targets and incentives; the trust of the public in the NHS is also at stake. His research identifies trust as a primary concern: if the public does not trust the reforms, then long-term support for welfare through tax may be at risk. According to modern, rigorous performance management systems, services do seem to be getting better. But according to Professor Taylor-Gooby, these improvements have come at the expense of public trust. In his analysis, trust has two distinct drivers: rational trust, which is based on evidence, such as published hospital performance scores, and is linked to user satisfaction; and non-rational or 'affective' trust, which is based on the belief that the NHS holds central the interest and

New Labour policy has been that health practitioners should respond to patient 'wishes' as well as their needs.

values of its users. Here lies the paradox: how can an NHS focused so entirely on meeting government targets truly be driven by a concern for service users as individuals with personal needs and wishes?

But as Dr Greener explains, a true consumerist agenda has another element to it: in the 'new public health', government is increasingly explicit about the relationship between choices in everyday life, and choices in treatment – implicitly requiring patients to take personal responsibility for their health choices. And this is where we find perhaps the greatest dilemma in today's NHS: the conflict between our rights as individual consumers to a non-judgmental, free at the point of delivery service and the realities of a resource-stretched NHS struggling to provide a safety net for some largely self-induced illnesses. In this context, where do our consumer rights end and our responsibilities begin?

Sir Derek Wanless, in a report commissioned by the King's Fund, is clear: the vast sums invested in extra pay, at his recommendation, will be wasted unless more is done to combat obesity. Without this, according to Wanless, the NHS will struggle to become a 'world class' service as resources are stretched ever more thinly to deal with increasingly unhealthy customers. All the targets and incentives, choice and responsiveness, shorter waiting times, better equipment and better mental health care could come to nothing unless obesity is addressed. The NHS of the next decade must find a way to offer choice to consumers without being slave to the consequences of consumerism. ■

<http://www.consume.bbk.ac.uk>
<http://www.bris.ac.uk/CMPO>
<http://www.publicservices.ac.uk>
<http://www.kent.ac.uk/scarr>

Social housing in the 21st century

FOUR KEY ISSUES THAT NEED URGENT ATTENTION

PROFESSOR JOHN HILLS, Director, ESRC Centre for Analysis of Social Exclusion, London School of Economics



SOcial housing provides stability and security for nearly four million households in England. Its quality is usually significantly higher than low-income tenants could afford in the private sector. It has kept housing affordable for tenants even as real house prices have doubled. And social landlords – housing associations and councils – often play a leading role in neighbourhood regeneration.

This focus on the individual may be in part a product of a subtle shift in political rhetoric, particularly in the Labour Party, in which Britain has been rebranded as a ‘market’ rather than as a ‘capitalist’ society. Here individual consumers are encouraged to make choices between both public and private goods and services, even when such ‘choice’ is in practice illusory.

There are four fundamental reasons why social housing can be a better response to housing need than alternatives, such as simply giving people cash benefits from which to pay private rents: its affordability; its quality compared with the private sector; its potential for supporting mixed-income communities; and its provision of a solid base upon which people can build the rest of their lives.

But the evidence suggests that we are not fully realising these advantages. Social housing has remained affordable – protecting tenants from what might have been the impact of doubled house prices – and the physical standard of much of the stock has improved. But there is disappointing evidence on tenant satisfaction, space standards and neighbourhood conditions (especially in areas originally built as flatted council estates).

The traditional policy aim may remain ‘a decent home for all at a price within their means’ but we may have given too little attention to the last part of that

Much social housing was built in the 1950s and 1960s as estates, originally containing families with a mix of incomes, but access to the sector since the 1980s has been increasingly based on need. This has exacerbated polarisation between different types of occupier rather than countering the effects of market forces.

Households living in social housing now have very high levels of worklessness. While some of this reflects the labour market disadvantages of many tenants, it is hard to see positive results from the work incentive advantages from the sub-market rents that social tenants pay.

There are four areas where attention is urgently needed, even if the supply of new housing is significantly increased, as promised in the Government’s 2007 Green Paper on housing:

■ **Increasing attention to the existing stock and tenant population:** successes and mistakes with the existing stock

can have much greater effects than the supply of new units. But the focus of landlords and policymakers is often much more on new stock.

Management quality is crucial: landlords have to be effective. But in a rationed, subsidised system, tenants cannot take their business elsewhere. This suggests that tenants who lack ‘exit power’ need to be involved in ways that give them ‘voice power’. Quality in housing includes the ability to move, which is becoming increasingly difficult and constrained.

■ **Supporting mixed-incomes within existing communities:** while new housing now usually involves a social mix, there has been much less progress with the existing stock. We need to think more imaginatively about how the location of social housing can become more diversified. Most fundamentally, to improve the income mix in areas dominated by social housing, we need policies that better support the paid work options of existing residents.

■ **Supporting livelihoods:** we think of employment and housing in separate boxes, but housing problems often have their roots in the labour market. Progress could be made through improving the way that housing benefit operates, improving links between employment and housing support services, and making it easier for social tenants to move for work-related reasons.

■ **A ‘more varied menu’:** instead of there being just a single unchanging product available to meet housing needs, there should be a more varied and flexible menu of options for both existing and potential new tenants.

For those with a margin above paying a social rent, low-cost home ownership options may be preferred by them, and cheaper for the government in the long run. For new and existing tenants, a regular review every few years could also run through whether their circumstances had changed enough to allow them to take up different options – from simple savings payments on top of rent to part equity purchase.

If social housing is to fulfil its potential, new approaches are needed. We need to move beyond an approach where the key function is trying to establish who is not eligible for social housing to one where the key question is ‘How can we help you to afford decent housing?’ and ‘Here are your options’.

Within this, housing in itself is not the only issue. The traditional policy aim may remain ‘a decent home for all at a price within their means’, but historically we may have given too little attention to the last part of that – doing enough to support people’s livelihoods and so boosting the means at their disposal. ■

Professor John Hills, *Ends and Means: The future roles of social housing in England, CASE report 34*, commissioned by the secretary of state for communities and local government.

<http://sticerd.lse.ac.uk/case/publications/reports.asp>

COMPETING FOR WHAT? TUITION FEES AND BURSARIES IN ENGLAND

Where is all the bursary money going?

THE 2004 HIGHER Education Act signalled a radical shift in student finances in England. Now all full-time undergraduates, irrespective of their family's income, pay tuition fees of up to £3,000, usually via a student loan. At the same time, higher education institutions that charge the maximum fee must provide bursaries of £300 to low-income students to supplement their state-funded grants and maintenance loans. While this is a mandatory minimum, the Government wants universities to provide additional discretionary financial support to promote widening participation.

The introduction of variable tuition fees was intended to create a more competitive market within higher education. But contrary to the Government's aim, there is no market in fees. Currently, all but four universities are charging the maximum fee of £3,000 for a degree and none are charging zero. The new 'maximum' has turned out to be a revised flat-rate fee. But as research by Professor Claire Callender, currently of London South Bank University, shows, a market is emerging instead in extra-statutory student bursaries. Her study as part of the Families and Social Capital Group finds stark disparities in the amount of money universities are investing in bursaries and in the nature and scope of the support they offer.

The proportion of tuition fee income spent on bursaries ranges between 11 and 78 per cent, while the value of the bursaries on offer ranges from £300 to £5,000 a year. This means there is a considerable difference between what the Americans call the 'sticker price' of £3,000 and the discounted



All full-time undergraduates in Britain today pay tuition fees of up to £3,000, regardless of family income.

price – that is, the tuition fee minus the value of any bursary. Since this difference varies from one university to another, we are seeing some tuition fee variation via the back door of bursaries.

Universities are using their bursary schemes and policies as a competitive strategy to assist their institutional repositioning in the higher education marketplace. For some, bursaries are an investment, a means of opening up opportunities to the brightest and the best. For others, they are a cost, a means of maintaining student numbers.

In the 117 universities Professor Callender studied, she found over 300 different bursaries or scholarships developed as a direct result of the 2004 Act. Most are targeted at certain types of students, but not just those from the poorest or most disadvantaged families; some are designed to attract local students while others are trying to draw in students to study subjects in which there are shortages of graduates. Other schemes aim to reward academic ability or encourage progression and retention. And some bursaries cover specific costs, such as accommodation, travel and fees, or additional costs such as when studying abroad or on a work placement. Indeed, one university gives a fee discount to students with a sibling attending the same institution.

Each university stipulates its eligibility criteria for extra-statutory bursaries and how much it will award. This may be advantageous for the universities but it does not necessarily help the students, adding to the complexity of the funding system. And since the bursaries are not an entitlement, students have to apply for them – and many are not applying.

Government figures indicate that almost two thirds of young people are unaware of bursaries. And many students think they are ineligible or are deterred by their complexity because information is unavailable or unclear. Consequently, bursary take-up was poor in some universities in 2006/07 – an inevitable consequence of a discretionary student



AT A GLANCE

The 2004 Higher Education Act was meant to widen participation, but our universities are now in danger of awarding too many bursaries on the basis of student merit rather than financial need.

IS MATRON THE BEST WEAPON AGAINST MRSA?

GORDON BROWN'S commitment to 'deep clean' hospitals and double the number of matrons is what the public wants, according to research from University College London. What's more, the decision to drop the term 'modern matron' – introduced by Labour in 2001 – in favour of old-fashioned 'matron' is in tune with popular demand for a return to the authoritative figure epitomised by Hattie Jacques in the *Carry On* films.

In a study of public knowledge of Methicillin Resistant Staphylococcus Aureus (MRSA) 60 adults were asked about their understanding of the disease. "While most participants told us they felt ignorant about what MRSA is, this was coupled with confidence in their judgements regarding MRSA's causes and solutions," explains Dr Helene Joffe.

Interviewees were almost unanimous in the view that MRSA is associated, first and foremost, with dirty hospitals. They saw the MRSA crisis as a consequence of neglect and mismanagement of the NHS, which is, in part, seen as a microcosm of the state of the country. The solutions proposed were improved hygiene in hospitals, better public education and bringing back the role of the matron. Many participants expressed nostalgia for a supposed golden age of the NHS.

"One striking and commonly held view was that the role of the hospital has been transgressed," Dr Joffe notes. "A patient enters hospital with an ailment and, instead of being cured, ends up with something worse: MRSA." Yet rather than this making participants anxious, most saw themselves as unlikely to come into contact with MRSA since it was largely confined to 'risk groups', such as the elderly.

The study also found that media messages about MRSA resonate, except that in newspapers there is little 'blaming' of foreigners for MRSA, while a sizeable minority of participants felt that foreigners were responsible for bringing in diseases, including MRSA, from abroad. They also suggested that foreign NHS staff and subcontracted cleaners were deficient in knowledge, good practice, communication skills and motivation.

"In the biomedical sphere, the chief cause of MRSA is seen as the overuse of antibiotics, leading to antibiotic resistance," Dr Joffe comments. "But lay people do not engage with the idea of antibiotic resistance; they engage with the issues of dirt, hygiene and structural problems in the NHS." In this regard, Gordon Brown clearly has his finger on the national pulse. ■

http://eprints.ucl.ac.uk/archive/00002080/01/Microsoft_Word_The_Hospital_Superbug_-_Social_Representations_of_MRSA.pdf



aid system. An additional problem is that some applicants do not know how much, if anything, they will receive before they start their course. This makes financial planning, which the Government is encouraging students to do, very difficult.

It is too early to know how many and what kinds of students will receive bursaries, or what impact the bursaries are having on widening participation and student behaviour. But lessons can be learned from the United States, which has a long history of both deregulated fees and institutional grant giving – and which Professor Callender is now visiting as she develops this research at the Harvard Graduate School of Education as part of her Fulbright New Century Scholarship.

In the United States, higher education institutions have an instrumental view of financial aid. Student support is part of a university's competitive position and is integral to their enrolment strategies. Rather than eliminate price as a factor in university choice – the official ideology in 'meeting need' in England's student funding policies – United States universities are turning net price to their advantage in the struggle for students.

Private United States colleges and universities have historically provided most institutional grants. But in the last 20 years they have grown by more than 300 per cent in public universities. Spending has risen, as have the proportions of students receiving support, especially undergraduates in the highest income quartile. Much of this increase has been awarded on academic merit rather than financial need. As a result, middle and high-income students are more likely to receive aid than their low-income peers. Already, a quarter of bursaries in England are awarded purely on merit and a half exclusively on financial need. Will England too end up with a bursary system that favours wealthy students and undermines widening participation? ■

www.lsbu.ac.uk/families/index.shtml

AT A GLANCE

The public believes that the MRSA virus is associated, first and foremost, with dirty hospitals rather than antibiotic resistance. Their solution? More old-style matrons and fewer foreigners working in the NHS.

CARE FOR THE LEARNING-DISABLED: POWER TO THE RESIDENTS?

Homes for the learning disabled are struggling to involve residents in decision-making processes



THEY ARE MEANT to be more 'person-centred', caring and respectful, but do modern residential homes for people with learning disabilities deliver on this? How do you 'empower' residents who find it hard to communicate? Even with the best intentions this can be hard to achieve, judging from the results of a new study led by Dr Mick Finlay of the Identities and Social Action Programme. The research used audio and video recordings to examine how staff and users in a residential home interact on a day-to-day basis.

Empowering residents may sound easy, but in reality there are a number of conflicting responsibilities. Residents with learning disabilities find it difficult to voice needs and concerns, particularly if they have problems understanding information. And while staff may want to encourage choice and independence among residents, they are also responsible for safety, hygiene and interventions, and they have to answer to service managers and parents as well as to the residents.

The research found that staff solved dilemmas between care duties and empowering the residents in a number of ways. Not all methods were successful and some were in direct conflict with the aim to respect and promote choice. For example, time pressure due to meal preparation and meetings could lead to staff rushing or cutting short interactions with residents. Staff tended to rely on verbal communication, but many residents had problems understanding what was being said. Staff would often repeat the questions, which could lead to confusion and residents changing their minds. Although residents were given choices, these were limited, and the possibility of a free choice between the alternatives was restricted.

In one case, staff explored residents' views on relationships with people around them. During the course of the conversation, it changed from

One problem is that people with learning difficulties can find it hard to voice their needs and concerns.

solicitation to instruction, in which residents were told to view staff as friends rather than carers.

This is a problem: as the researchers point out, to specify a category is also to imply roles, hierarchies, obligations and repertoires of behaviour. If staff are seen as friends, their motivations and loyalties cannot be questioned. A relationship of 'friendship' implies equal status but it can obscure the real interaction of power and control.

Time pressure was evident in two incidents where residents were gathered to identify problems and come up with potential solutions. In one case, the facilitator initiated each stage of the decision-making process. In the other, the facilitator 'short-circuited' the decision-making process, jumping straight to the conclusion. The first case was closer to involving the residents in decision-making, but both cases prevented them from taking the initiative.

Cases of residents refusing to do what they were told were treated as temporary reluctance, followed by further attempts to persuade the person to co-operate. Ways of dealing with this situation included repeating the invitation in a 'no-blame' manner, minimising the task required, escalating the invitation to a request and an order, physically moving the person or glossing the proceedings. Dealing with refusals illustrates the dilemma of staff in accepting residents' choices when these choices might disrupt service management.

Video recordings of the kind used in this study are valuable for practitioners as well as researchers. For example, they show that people with very limited spoken language will use non-vocal gestures to contribute to the conversation – but these are not always noticed by their carers. The recordings could also be highly useful in training staff, as they allow them to see their own behaviour. ■

AT A GLANCE

How can staff and users interact in residential homes for the learning disabled to resolve conflict between empowerment and staff management responsibilities?

<http://www.identities.org.uk>

REDUCING CRIME BY TARGETING PROLIFIC OFFENDERS

An efficient and cost-effective strategy?

THE GOVERNMENT'S 'prolific and other priority offenders' (PPO) strategy, launched in September 2004, aims to reduce crime by targeting the most prolific offenders. Research by Professor Stephen Machin and Olivier Marie from the Centre for Economic Performance, which has assessed the impact of a series of PPO pilots introduced in particular areas, finds evidence of modest reductions in crime rates as a result of the scheme, notably for burglary and vehicle crime.

The Government estimates that ten per cent of the one million active offenders in England and Wales commit half of all crimes. Of those, a hard core of 0.5 per cent of offenders is responsible for almost one in ten of the total 12 million offences. In theory, it could be cost-effective to try to reduce crime rates by targeting resources at decreasing the frequency of offending of this group. High offending frequency or concentration could make it more efficient to try to cut crime rates by targeting prolific offenders than by trying to prevent the participation of the common, 'single crime' individuals.

Admittedly, the magnitude of crime rate reduction would depend on a combination of offending concentration in an area, the types of crime committed by prolific offenders, and accurate selection of the individuals to target. Still, the benefits could be above and beyond a short-run reduction in the targeted individuals' offending, with possible decreases in their influence on participation in crime by others and an acceleration of the end of their criminal careers.

So how do PPO schemes work? The target population of persistent offenders is identified from the volume and nature of crimes they commit and how damaging those individuals are to their local community. Local area agencies in charge of crime prevention then work together to reach the PPO's three stated goals: 'prevent and deter';



There have been modest reductions in crime rates as a result of PPO pilot schemes, notable for burglary and vehicle crime.

'catch and convict'; and 'rehabilitate and resettle'. The recommendation is that the schemes adopt a 'carrot and stick' approach to offender management, the 'carrot' being the enhanced levels of support services offered to the PPO and the 'stick' being the increased (unwanted) police attention should the offender choose not to comply.

Prior to the introduction of the national PPO strategy, several basic command units in England and Wales ran their own pilot programmes, which varied in length, resources and implementation. The study evaluated these by seeing whether they had any identifiable impact on crime rates in the areas that introduced them relative to those that did not.

The researchers find some evidence that crime fell in areas that introduced PPO pilots relative to those that did not. But crime reduction is only observed for some types of crimes, namely burglary and, to a lesser extent, vehicle crime. These are the types of crimes that prolific offenders are most likely to commit. Perhaps not surprisingly for a policy programme of this sort, the crime reductions that are identified across areas are relatively modest in magnitude. Nevertheless, a six to seven per cent reduction in burglaries from targeting a very small number of individuals could be considered a success and of interest to a crime-fighting strategist.

This is an average effect across areas and more research is needed to investigate which schemes are more efficient and why. It is also important to establish the cost-effectiveness of policies that focus on prolific offenders and reduce concentration, especially when compared with general crime reduction initiatives aimed at preventing any participation in crime. ■

For details on estimated numbers of prolific offenders, including the sources of official government statistics used in the calculations, see: www.crimereduction.gov.uk/ppo/ppominisite01.htm

AT A GLANCE

Areas running PPO pilot schemes have seen a reduction in burglary and, to a lesser extent, vehicle crime. The strategy seeks to 'prevent and deter', 'catch and convict', and 'rehabilitate and resettle' our hardcore criminals.



<http://cep.lse.ac.uk>

NHS DENTISTRY: THE POWER OF INCENTIVES

THE NHS CONTRACT for dentists in England and Wales introduced in April 2006 has led to a sharp increase in the number of NHS treatments. Research by Dr Jan Clarkson of the Public Services Programme suggests that the new contract, which pays dentists a fixed monthly amount rather than a fee per item of service, increased the number of treatments per month by 27 per cent compared with Scotland and 59 per cent compared with Northern Ireland.

But although NHS treatments increased, the dentists showed a less positive attitude to work than dentists in Scotland and Northern Ireland. The analysis suggests that the change in contract increased dentists' fear of making mistakes and litigation. The contract also led to a decrease in the number of so-called 'band 1' treatments such as clinical examination, x-rays, scaling and polishing, and preventative dental work such as hygiene instruction. At the same time, there was an increase in 'band 2' treatments, which include relatively simple procedures such as fillings and extractions.

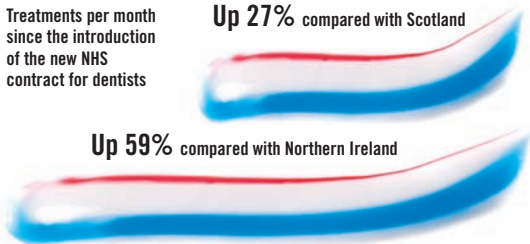
The results indicate that under the new contract, dentists are less likely to provide a diagnostic and preventative band 1 treatment and more likely to provide simple restorative band 2 treatments. ■

<http://www.publicservices.ac.uk>

Treatments per month since the introduction of the new NHS contract for dentists

Up 27% compared with Scotland

Up 59% compared with Northern Ireland



CAN PAY REGULATION KILL? EVIDENCE FROM ENGLISH HOSPITAL TRUSTS

The effects of centralised pay setting in the NHS

NOWHERE IS CENTRALISED pay setting more important than in the NHS. More than a quarter of a million nurses in England have their pay set by a single pay review body. The process allows some local flexibility, but in practice the gap between the wages paid to a nurse in Newcastle and one in London is small compared with the pay gap between women who are not nurses.

Economists have long warned of the unintended consequences of labour market regulation. Some things that seem fair – like paying people the same amount of cash for doing the same job regardless of where they work – may turn out to be foul when subject to closer scrutiny. People often worry about the minimum wage pricing people out of jobs, but when pay in a sector is set to be almost the same across the country, it effectively imposes a maximum wage on people living in parts of the South East where labour markets outside the sector are strong.

This kind of centralised pay setting happens in many public sector labour markets, such as health, teaching and the police. Research by Professor Carol Propper of the Centre for Market and Public Organisation and Professor John Van Reenen of the Centre for Economic Performance has looked at how

Segregation in schools

How much are high-achieving and low-achieving pupils in England separated into and educated in different secondary schools? According to research by Dr Stephen Gibbons and Dr Shqiponja Telhaj from the Centre for Economic Performance, the average ability of children going into the 'best' comprehensive schools is way above the average ability in the worst. What's more, such educational 'segregation' is even greater when the analysis includes schools that can 'cream skim' pupils by picking according to ability or have other attributes – such as religious ethos – that make them likely to attract or choose pupils of different types and abilities.

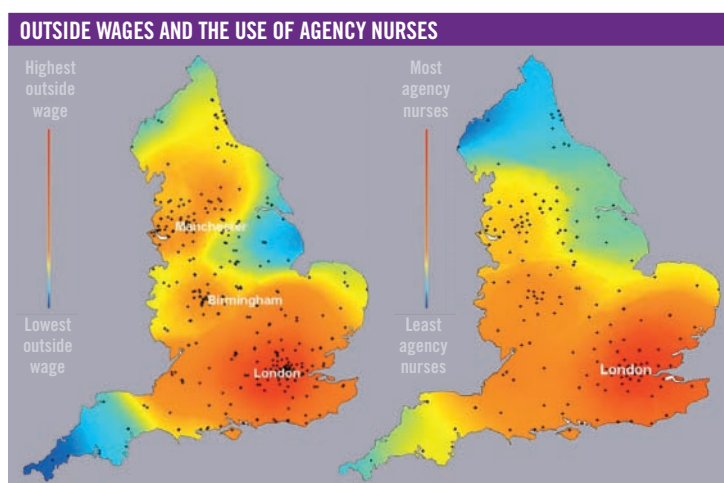
But the research also finds that while there are these strong differences in school intakes, almost nothing has changed since the mid 1990s

in how pupils of different abilities are sorted into different schools. There is segregation by ability in English schools, but the idea that pupils of high ability and low ability have become increasingly segregated over time is something of a myth.

The researchers also studied how segregation by ability affects educational outcomes. Certainly, children in schools with low-achieving children are more likely to do badly later on, while pupils surrounded by high-achievers are more likely to do well. But is this just because high-ability pupils and low-ability pupils tend to go to different schools? Or does our 'peer group' matter?

The evidence here is based on what happens to educational trajectories when pupils move from primary to secondary school and meet new schoolmates. This innovation in peer group quality





centralised pay setting for nurses in the NHS affects hospital performance by tracking changes in the outside wage and changes in performance in over 100 English hospital trusts over a six-year period.

Common sense would say that hospitals in places where outside opportunities are better are going to struggle to recruit, retain and motivate staff. This is exactly what the study finds: in areas like London where the outside labour market is strong – where the wages of nurses are lowest compared with their non-nurse counterparts – nurse vacancy and turnover rates are higher and fewer qualified nurses work in the NHS.

But these staffing problems are not confined to the human resources department. More worryingly, they feed into a lower quality of service and poorer outcomes for patients. Hospitals in areas where the outside labour market is strong have lower volumes of activity relative to their staffing levels. They also have higher fatality rates among patients admitted with emergency heart attacks.

None of these effects are present in firms operating in the private sector. Nor do they seem

In the first map, the areas with the highest outside wages are marked in red, those with the lowest outside wages in blue. The second map shows the intensity of use of agency nurses.

to arise because hospitals in high cost areas face greater financial problems or have sicker patients – in fact, patients in high external wage areas generally have better health than those in low external wage areas.

One key problem is that hospitals that find it difficult to recruit permanent staff rely more on temporary staff. Such nurses can be paid at a higher rate but tend to have less experience and training, and will not know the hospital as well as permanent staff.

The maps on the left show the link between outside wages and use of agency nurses. The spatial distributions of the two maps are very similar: where outside wages are high, use of agency nurses is high. Put starkly, centralised pay regulation means hospitals in high wage areas treat fewer patients and these patients have poorer health outcomes. These effects are not trivial. The results suggest that a ten per cent increase in the gap between the wages paid to NHS nurses and those paid to women in the private sector locally raises the fatality rate among people admitted with a heart attack by five per cent. Applying the same value to a life saved as used in the regulation of new drugs, a five per cent higher death rate costs society as much as £26 million.

Some may say this is a price worth paying for equality. But equality is in the eye of the beholder. Living expenses are much higher in London and the South East so £1,000 in inner London buys a much lower standard of living than £1,000 in Lancaster.

The study uses data from 1995 to 2002 and there have been some relaxations in the rules since then with more recruitment bonuses and cost of living allowances. But it is still the case that public sector workers are taking a much bigger effective pay cut compared with similarly skilled workers in lower-cost areas. ■

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can be used to examine whether the differences between school intake have any influence on a pupil's subsequent progress in tests up to age 14.

The study finds that pupils do make better progress in maths and English in the early stages of secondary school if their new schoolmates have a good record of prior achievement. And it really is the prior achievement of peers that seems to matter: other contextual factors, such as ethnic mix, age composition and low-income schoolmates have no direct effects on a child's progress.

This is encouraging because pupils' prior attainments are surely more amenable to early interventions than socio-economic and demographic characteristics. But it also means that the patterns of segregation observed in secondary schools could have real consequences in terms of educational inequality.

Even so, the researchers find that any contribution peers make to a child's academic

progress is quite small: a move from the worst to the best comprehensive school would make only a slight difference to how well a child progressed in their first few years at secondary school. It seems unlikely that educational success or failure will be tipped according to whether a child attends a school alongside high- or low-ability children.

This claim might seem puzzling given that parents seem to go to great efforts to find schools with good peer groups. But better peer groups perhaps provide other benefits – physical safety, emotional security, familiarity, lifetime friendship networks or simply exclusivity – which makes schools with good peer groups very desirable, even if they offer only slight academic advantages. Perhaps it is here that individuals really win or lose out through both socio-economic and achievement-based school segregation. ■

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British transport policy

PROBLEM AREAS THAT HAVE NOT BEEN ADDRESSED

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IN 1989 MARGARET THATCHER launched Roads for Prosperity – ‘the biggest road programme since the Romans’ – and in 1997, John Prescott launched A New Deal for Transport, the theme of which was ‘we can’t build our way out of trouble’. What happened in between was a fundamental reappraisal of the relationship between traffic growth and road building. It became clear that it was not actually feasible to build road capacity fast enough to keep pace with the unrestricted growth of traffic. It just couldn’t be done. The consequence was a matter of traffic theory not political will – if road capacity did not keep pace with traffic growth, congestion had to get worse, in duration, intensity or geographical spread.

This was the reason why the instruments of travel demand management became so important – road pricing, traffic restraint, public transport priority, walking and cycling measures, and all the ‘soft’ methods of influencing behaviour. It was not primarily due to environmental objectives at the beginning, but because nothing else really offered a hope of working. This was especially true after 1994, when a government advisory committee finally demonstrated beyond doubt the evidence that road building leads to an increase in the volume of traffic.

So what on earth is going on now? The Conservatives offer a twin track, with one study group appearing more radical than Prescott ever was, and the

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other harking back to trying to provide road capacity for private cars.

The government keeps a firm hold on the ten-year rule for road pricing: in other words, it is always ‘possible within ten years’ – a proposition first advanced in the report of a Ministry of Transport-appointed panel led by Ruben Smeed in 1964, and repeated every ten years or so since. But it also publishes calculations that seem to show that road building produces a social ‘profit’, mostly time savings, of five or even ten times the cost of building.

Ken Livingstone defends one of his pet projects, the Thames Gateway Bridge, which was rejected by the inspector at a public inquiry, with the suggestion that cars will become so clean that there will be no environmental dangers in encouraging the growth of traffic. And meanwhile, on the ground, the same local and national authorities that are bidding for funds to build roads to regenerate the economy are simultaneously adopting new and radical methods of discouraging car use (with very considerable success, in many cases: the best plans reduce

car use by up to 20 per cent, almost unnoticeably). All seems confusion. Where is the coherence, the strategy, that makes sense of all this? There are three problem areas that have not been addressed. The first is forgetting the lesson of the 1990s: that if road building does not actually make traffic conditions better, it cannot help any of the other objectives. The appraisal methods almost never offer making things better – they offer ‘slowing down the pace at which it gets worse’ – for 30 years, and now for 60 years. In the cost-benefit arithmetic, this is shown as a benefit, but in the real world, conditions deteriorate.

The second is fundamentally over-simplifying how changes in behaviour actually happen. There is now a large body of evidence from practical research (much of it funded by the ESRC, while all this was happening, from 1994 to 2004) that travel habits do change, and in a large way, but not swiftly and not simply. What governments

have always got wrong in transport is the relationship between ‘habit’ and ‘change’. Habit dominates in the short run, but over a period people are very much more adaptable than is generally thought, especially at times when life-changes happen for other reasons, like moving or having children or retiring. And that means that it takes between

five and ten years for the effects of policies to build up, and only if they are consistent and persistent.

The third is a disjunction between ‘urban’ and ‘interurban’ travel policy.

There is a myth that you need large-scale motorways for long distance travel, and small facilities for local travel. But by far the majority of movement is short distance – even on the motorways themselves. Enlightened city planning sees that the boulevards, the grand axes, the squares can be both large-scale and pedestrian.

It is widely agreed that massive road building in cities does more harm than good, and equally widely assumed that the economy needs the new infrastructure between the cities. But to unload huge increases in traffic from an expanded interurban road system onto an unexpanded local road system is just silly. Paris is very interesting just now. The city is progressively taking traffic space away – not just on small shopping streets but on some of the major routes, which now offer one lane for cars, one lane for buses and an extra width for pedestrians, cafes and shops. This is actually beginning to happen in Britain as well, but the budgets and the professional career prospects and the flair have not kept pace. It is happening, but our hearts are not yet in it. ■

<http://www.transport.uwe.ac.uk/staff/phil.asp>

