

# Information, information, information: transparency and open public services

**A key aim of the White Paper is to make information on the quality of public services more transparent so as to raise standards. CMPO's Deborah Wilson reviews the evidence on performance indicators and 'management by numbers'.**

The White Paper emphasises the devolution of power over public services to the lowest appropriate level. In the case of individual services, such as health, education and housing, the aim is to put power in the hands of service users. This implies a continued focus on 'choice and voice' as the means by which improvements in standards can be realised:

'Our plans to create open public services replace bureaucratic accountability with democratic accountability' (para 5.21)... 'Providers will be held to account through a combination of mutually reinforcing choice, voice and transparency mechanisms, depending on the service being provided' (para 5.26).

Publication of information on the performance of service providers is central to achieving transparency:

'To make informed choices and hold services to account people need good information, so we will ensure that

key data about public services, user satisfaction and the performance of all providers from all sectors is in the public domain in an accessible form' (para 3.4).

This article reviews the evidence on the use of performance indicators (PIs) as part of the 'management by numbers' of public service providers in light of the aims of the White Paper (Hood et al, 2009; Wilson, 2010). What do we know about different kinds of PI? How do providers respond to the publication of PIs and does that improve service quality? And within which kinds of accountability mechanism are PIs most effective?

## Three kinds of performance indicators

PIs come in three general forms. The simplest are measures of the outcomes of a provider at some designated date: the percentage of patients in a hospital who do not die after emergency admissions for heart attacks, for example, or the percentage of pupils in a school who achieve five GCSEs at grade C or above.

While easy to understand and relatively low cost to collect, these PIs deal with only one dimension of a potentially complex output. Such simple PIs also fail to take account of the characteristics of the users being served and how, say, the wealth or health of those users might affect the measured outcome.



One implication is that the PIs may unfairly penalise effective providers serving disadvantaged and higher cost populations while concealing poor or 'coasting' performance from providers serving lower cost populations. A second implication is that PIs are susceptible to 'cream skimming': by adjusting the quality of its intake, a provider can boost its performance as measured by raw outcomes.

## Performance indicators are most effective within a system of accountability that links success and failure with explicit rewards and sanctions

Risk-adjusted or value-added PIs take account of differences in intake. Thus, they are better able both to reduce the incentive to cream skim and to isolate the impact of, for example, the school environment on pupils' progress over time. But generally they still only reflect one dimension of output.

One response has been the development of composite indicators that attempt to combine many dimensions of a provider's output into a single figure. Examples include the star rating of hospitals in England and the system of 'comprehensive performance assessment' for evaluating local government. While intuitively appealing and easy to understand, in practice these indicators are somewhat opaque and can be extremely sensitive to the methods used to produce them.

Despite their shortcomings, all three forms of PI are likely to feature, often concurrently, in the coalition government's plans to provide sufficient performance data to enable informed choice. And where data are published to encourage explicit comparison between alternative providers, rankings and league tables are bound to follow.

Two points are worth highlighting here. First, what may appear to be an ordered ranking of providers on the basis of a specific PI may in fact be largely spurious if the statistical uncertainty involved in calculating that PI is not explicitly taken into account. For example, CMPO research shows that over half of all secondary schools in England are not significantly different from the national average when 'ranked' on their contextual value added scores, a measure of pupil progress that takes account of social factors (Wilson and Piebalga, 2008).

Second, the same provider is likely to have different positions in ranking exercises depending on which aspects of performance are measured, resulting in conflicting rankings. With transparency comes complexity, and the extent to which a balance can be achieved that maximises the benefits of this inevitable trade-off for individuals choosing between public service providers is an open question.

### Do performance indicators improve public service quality?

The aim of the White Paper's shift towards democratic accountability through increasing choice and voice is to improve the quality of public service provision while not increasing spending:

'We believe that when people have the power to make decisions and exercise choices to meet their own needs, the value of public funds can be greater than when the state makes decisions for them' (para 1.10).

The need to justify the resources used to implement the measurement systems required to inform such choice may be particularly important in the current era of fiscal constraint, given the opportunity cost of not employing resources on more 'frontline' uses. Accompanying this will be a heightened political need to demonstrate success: to show that public service outcomes are improving as a direct result of the emphasis on user-based accountability mechanisms.

While there is a large and growing body of evidence on how individuals and organisations respond to 'management by numbers', there is less on the extent to which PIs actually improve public service quality, and even less on the costs of achieving any such improvement. This is partly due to the difficulties of isolating the effect of PIs themselves, given that they have generally been introduced as part of broader programmes of reform.

## With transparency comes complexity – and a trade-off for individuals choosing between public service providers

In some areas, PIs do appear to have improved public service performance. For example, CMPO research shows that the abolition of secondary school league tables in Wales in 2001 reduced school effectiveness relative to England by an average of almost two GCSE grades per pupil per year (Burgess et al, 2010). Other CMPO research shows that waiting times for elective surgery fell faster in England than in Scotland in the early 2000s, when the English PIs were linked to sanctions for missing waiting time targets that were not in place in Scotland (Propper et al, 2010).

But sometimes service improvement in measured aspects of performance has been achieved at the cost of distortions to provision in other, unmeasured aspects, as in the case of the Quality and Outcomes framework introduced for family doctors in 2004.

More generally, there are many examples of 'gaming' and other undesirable responses to PI regimes. League tables provide the incentive to focus effort on boosting the published

measure, possibly to the detriment of other, unmeasured aspects of performance. There are numerous examples in education, including evidence of schools focusing attention on the so-called C/D borderline pupils: while this can raise the percentage of pupils achieving five GCSEs at grade C or above, it can also be to the detriment of the progress of lower ability pupils in the school.

## Performance indicators invariably leave some opportunity for undesirable as well as desirable responses from providers

### Within what accountability mechanisms are performance indicators most effective?

So there is some evidence that PIs work, particularly when the output is clear and focused as in the case of hospital waiting times, but that such improvements may be accompanied by other, less desirable responses. But PIs do not work in isolation but as part of broader performance management regimes. Such regimes incorporate rewards for success and/or sanctions for failure that create consequences for providers and thereby incentives for service improvement.

In theory, such consequential accountability can be achieved using PIs as part of user-based mechanisms such as choice. A classic example is a 'quasi-market', in which providers of services are rewarded for good performance by gaining more contracts, pupils or patients, for example, and thereby more funding. Consequences can also be imposed as part of 'top-down' incentive schemes: hospital managers in England faced dismissal if their hospital performed poorly against waiting time targets, but gained the freedom to keep certain surpluses if they performed well (Propper et al, 2008).

While the language of the White Paper is very much in terms of increasing democratic accountability through choice and voice, there is still an acknowledged role for the state:

'As information about services becomes more transparent, people should be able to make more informed choices about the providers they use... and elected representatives should be able to scrutinise providers more effectively on people's behalf' (para 1.23).

In addition, there is an explicit role for the state as guarantor of minimum performance standards that will be raised over time, accompanied by a 'zero tolerance' of failure. So in practice PIs will form part of concurrent democratic and bureaucratic accountability mechanisms.

The evidence suggests that PIs have been most effective in achieving performance improvements through their use as part of bureaucratic accountability mechanisms, which link success

and failure in terms of measured performance with explicit rewards and sanctions. The evidence on the use of PIs in conjunction with user-based accountability mechanisms such as choice is much more mixed.

In education, for example, it is far from clear that school choice in England has improved the academic performance of schools. In the comparison of England and Wales, the relatively low level of potential choice in Wales suggests that it is unlikely user-based accountability via parental choice is the main driver of the results.

In the context of healthcare, the evidence suggests that while consumers claim to want information on hospital performance, they do not in practice make great use of the data. Indeed, direct patient choice is limited in many healthcare systems. There is also evidence that some patients need more guidance in processing complex performance information, which has additional implications for equity.

### Conclusions

The alternative forms of PI leave some opportunities for undesirable as well as desirable responses from providers. Encouraging service users to make explicit comparisons of performance gives providers incentives for both kinds of response.

Given that the evidence suggests that PIs are most effective within a system of bureaucratic accountability, the danger of increased transparency across numerous aspects of public service performance is that providers will respond to the new regime in undesirable ways. In particular, they may focus their efforts on attempting to rank highly on potentially conflicting performance measures to avoid bureaucratic sanctions, rather than responding to the needs of the full range of individual service users.

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### Further reading

Simon Burgess et al (2010) 'A natural experiment in school accountability: the impact of school performance information on pupil progress and sorting', CMPO Working Paper No. 10/246 (<http://www.bris.ac.uk/cmppo/publications/papers/2010/wp246.pdf>)

Christopher Hood et al (2009) 'Managing by numbers': the way to make public services better? (<http://www.publicservices.ac.uk/index.php/library/policy-briefing-paper-managing-by-numbers>)

Deborah Wilson and Anete Piebalga (2008) 'Performance measures, ranking and parental choice: an analysis of the English school league tables', *International Public Management Journal* 11(3): 344-66

Carol Propper et al (2008) 'Did "targets and terror" reduce waiting times in England for hospital care?', *The B.E. Journal of Economic Analysis & Policy* 8(2)

Carol Propper et al (2010) 'Incentives and targets in hospital care: evidence from a natural experiment', *Journal of Public Economics* 94(3-4): 318-35

Deborah Wilson (2010) *Targets, choice and voice: accountability in public services*, report for the 2020 Public Services Trust (<http://www.2020publicservicestrust.org/publications/>)