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PUBLIC INTEREST AND SOCIAL POLICY: IS THERE A SPACE FOR THE PUBLIC SUPPLY OF SOCIAL SERVICES?

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Public interest and social policy: is there a space for the public supply of social services?

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In the debate on reform of the Welfare State, it has virtually become a commonplace to deny the equivalence between public interest and public supply. The public interest could be perfectly satisfied by public provision, meaning, by it, a system where the public sector remains responsible for financing and overall guidance/regulation, but production is given to private organizations. In this perspective, private production, suitably designed, would constitute a win-win[1] solution, being perfectly able to satisfy the public interest.

Even though often associated with the demands for a new welfare, this idea is not new, being present since the golden years of the Welfare state. Suffice it to think to Lord Beveridge's plea for voluntary action. Also in Italy, it has been a recurrent theme as exemplified by the proposal put foreword, in 1980, by the *Rivista trimestrale*, in favor of a State playing only an intermediary role between, on the one side, individuals, families and enterprises expressing a demand of collective services and, on the other, private providers of these latter. Doubtlessly, however, only in these last years, thanks also to the support by the European Commission, it has gained a growing consensus.

The goal of the paper is to challenge this idea, sustaining the thesis that, in fields such as health care and compulsory schooling, public provision risks underrating different dimensions of public interest. These risks could be handled not simply by public supply, but by monopoly of public supply.

Any evaluation needs to be based on a rigorous specification of both the public interest and public provision. In this paper, I specify public interest as equality of opportunity to achieve some results deemed crucial to all, irrespective of the individual plans of life. Furthermore, I add a freedom requirement: not only the achievement of results should be granted as opportunity (rather than being imposed), but such an achievement should also be responsive to the demands of freedom. Given the focus on health care and compulsory schooling, the results considered are being treated if ill, and being trained, in the sense of acquiring the basic knowledge (in the different subjects) deemed necessary to enter adult life[2].

[1] On the notion of win-win solution, see Besley and Ghatak, 2003.

[2] Alternatively, one could have focused on being healthy or on additional results related to schooling, such as the capacity to interrelate with others and/or to develop autonomy. The emphasis on health would have required considering the many policies influencing health, besides health care and this is out of the scope of the paper. The other results associated with schooling are, instead, considered, but as having to do with the distributive dimension and with freedom.

I specify public provision on the basis of a version of the enabling welfare state – from now on, the enabling proposal -, characterized, besides by recipients'[3] empowerment through public financing of demand (rather than of supply), as all "enabling" versions, by three additional peculiarities. First, production is carried out primarily by non profit organizations, be they structured in a commercial form – the aim remains profit, but within a non-distributional constraint - or in a non commercial form. Non commercial organizations include the social and civil enterprises of the so-called civil economy[4], committed to the practice of "sociality", of doing things in common with others through peer relationships, as well as organizations committed to the intrinsic value (use-value) of the services delivered, irrespective of the value of sociality[5]. Second, public financing of demand takes place trough regulated prospective payments, in the form of non-toppable vouchers (the amount cannot be incremented through private resources) or of remuneration of providers on the basis of the demand of services satisfied (from, now on, for simplicity, on the basis of market share)[6]. More precisely, vouchers are considered for compulsory schooling and remuneration of the providers on the basis of market share for health care. The overall result is a competition on quality. Third, the public sector plays an extensive role in the diffusion of information, in regulation and in control, engaging not only in price setting and in the accreditation of private facilities, but also in the definition of the standard of services provided (and of working conditions).

Within the enabling proposal, the civil economy, intrinsically, and the overall non profit sector, possibly, would cooperate with the public sector, on the basis of horizontal governance networks, in the definition of in-kind transfers and in the overall design of the enabling proposal. Apart a few suggestions, the paper leaves, however, aside the decision-making process, concentrating on the delivery of services[7].

This acknowledged, why these specifications and not others? In brief, even though inspired by Sen's principle of equality of capability, the conception of public interest chosen appears quite widespread, associating the defence of distributive equality with freedom of choice. It could still entail too much distributive equality, for example, by those opposing in-kind transfers. The aim of the paper is, however, to question the defence of public provision and this latter takes for granted the legitimacy of in-kind transfers. If in-kind transfers were considered illegitimate, the only defensible solution would be general cash-transfers.

The utilization of the overall enabling perspective is justified by the emphasis on freedom of choice. Freedom of choice would not be promoted if public provision were characterized, for instance, by schemes of contracting out which, even though based on private supply, would involve public

[3] I prefer to refer to recipients rather than to consumers, the category of consumers having typically to do with a market-like typology of choice which, as discussed in the course of the paper, is only one among the typologies of choices that could be pursued within the enabling perspective.

[4] For an historical reconstruction and an elaboration of the notion of civil economy, see Bruni, Zamagni, 2004. The main difference between the two forms of enterprises is that the former would pursue sociality in production, while the latter in the organization of demand. The civil economy shares many elements with the perspectives both of the social quality markets. On this perspective see, De Vincenti, Gabriele (a cura di), 1999.

[5] For example, one may be intrinsically committed to given good practices, as in surgery, but disinterested in sociality. For a more complete description of many forms of non profit organizations, see OECD, 2003.

[6] Also vouchers entail financing on the basis of market share. Vouchers are, however, given to recipients of care and involve a bulk payment for an overall service. Remuneration of providers on the basis of the demand of services satisfied involves, instead, an indirect financing of demand and could also apply to single services. This should become clearer in the discussion offered in Section 1.

[7] This does not ignore the interrelations existing between the decision-making and the delivery aspects (the "what" and "the how"), legislation leaving many choices to be made at the delivery level. On the contrary, how to design "new forms" of participation in the decision-making at the delivery level is one of the most urgent and challenging area of research. On this, see for example, Bifulco, de Leonardis, 2005. Nonetheless, the paper substantially abstracts from these questions: even the civil enterprises are merely considered in delivery function.

financing of supply (rather than of demand). The specific version chosen, on its part, appears better suited to satisfy the chosen conception of public interest, thus, representing a more robust proposal. Obviously, it is more challenging to discuss a robust proposal than a straw dog.

Within the enabling perspective, in fact, public financing of demand could take the form of fiscal expenditure subsidizing both donations to non profit organizations active in the social field and/or private consumption of given social services. Vouchers could be toppable and, be they toppable or not, could be utilized also in health care. Competition could also be on price, as in the case of partially cashable vouchers. Moreover, even assuming in-kind transfers and the same financing mechanisms of the enabling proposal, delivery could rely on traditional market-like schemes, based on for profit organizations and isolated consumers' choices in a context where regulations and controls are limited and the diffusion of information is undervalued. Conversely, it could rely on the civil economy, while in the version chosen, the reference is to the overall non profit sector[8].

Fiscal expenditure and toppable vouchers, however, risk penalizing the worst off and vouchers, be they toppable or not, suffer additional disadvantages (compared with reimbursement of the providers on the basis of market share), if introduced in fields where heterogeneity of needs is as high as in health care and public administrators lack the information to differentiate accordingly the amounts. Furthermore, competition on prices, as in the cases of partially cashable vouchers, could lead to under-consumption of services crucial for the achievement of the desired results. For the market-like and the civil economy versions, the answer is less immediate. The risks range from those of exploiting informational failures to those of underrating many dimensions of freedom. These risks should become clearer in the course of the paper.

The analysis is structured around three building blocks constituted by the effectiveness in the achievement of results (in our case, being treated if ill and being trained); distributive equality (in the achievement of results) and the promotion of freedom[9]. I could also have referred to efficiency. For example, effectiveness has to do with productive efficiency with respect to the realization of results as well as with allocative efficiency with respect to the quantity of output necessary to produce the results. Moreover, freedom of choice includes welfare enhancing freedom that is sovereign in the prospective of allocative efficiency. The structure chosen appears simpler, sparing the need to constantly specify the meaning utilized.

The approach is mostly theoretical and aims at providing a birds eye view of the risks of the enabling proposal, drawing from contributions from different disciplines – welfare economics, health and education policies, political theory -. Reference to the empirical evidence is presented, selectively, to sustain the thesis advanced. This does not ignore that the empirical evidence is, in many cases, rather indeterminate. The goal, with the empirical evidence, is simply, to draw attention to many unsettled details undervalued by the enabling proposal.

The overall assumption is that more attention has to be given to the intermediate space between values and institutions, in order to avoid hastily connections insensitive to the complexity either of institutional working or of values themselves[10]. In this perspective, the dialogue among different disciplines becomes crucial.

[8] For a survey of the different versions of the "enabling welfare state", see Gilbert, 2005.

[9] More specifically, the first block concentrates on whether the enabling proposal is capable to ensure results even to the well-off, irrespective of the implications for the poor/socially disadvantaged, while the second block deals with these latter. Since the first block also considers some distributive implications (for example, for the more or less sick individuals), the term distributive equality is utilized in a restricted way, as having to do only with socio-economic inequalities.

[10] On the need to concentrate on this analytical space, see, for example, Bojer, 2006 and Rothstein (ed.), 1998.

2. The effectiveness in the achievement of results

As cogently argued by Bowles and Gintis (1999), one of the great ambition of competition on quality is to ensure accountability through a realignment of property rights (those of control and those of residual claimancy), that is to say, through localizing decisions and interests in the recipients of services[11]. For example, within public monopoly, teachers, as agents, have control rights on the education bestowed; school heads, in intermediate position between teachers and parents, have some information on it; parents/students, however, as the residual claimants, lack information and capacity to control the teachers. Competition on quality would invert the situation: thanks to exit, schools would become the residual claimant. If unable to attract students, they would be punished, losing students and, with them, revenues. This would stimulate schools to increase quality, thus, promoting the achievement of results. The same would happen within health care.

This ambition risks to remain unfulfilled. Let's start with health care, assuming, for the reasons above given, public financing of the providers on the basis of market share. The risk is, here, that rather than more accountability, the result is both oversupply and undersupply of the services delivered, meaning, respectively, that more or less services are being delivered than those that recipients with the same information of providers would demand.

More precisely, in the space of final output, the incentive[12] is to oversupply the more remunerative categories of services for which remuneration is contemplated (for example, within hospitals, shifting patients needing a less remunerative DRG - Diagnostic Related Groups - into a more remunerative one) and, within such categories, the less sick patients. Conversely, the incentive is to undersupply the least remunerative categories and the more sick patients, thus, producing respectively horizontal cream-skimming (that is to say, under-investment in the less remunerative specialties) and vertical cream-skimming or, in other terms, dumping. Also territorial discrimination could take place - for example, privileging investments in high density area -[13].

In the space of the intermediate output, the incentive is to undersupply *tout court*. Undersupply, in this space, could also be defined as skimping (Ellis, *cit.*). In order to increase market share and in so far as the payoff remains positive, some oversupply could, nonetheless, take place in the services that may act as a signal of quality for the recipients.

Oversupply and skimping are primarily made possible by informational failures: given the nature of experience and of trust good of health care, recipients may not know the quality of the treatment until the end of the process of care and, possibly, even afterwards, lacking medical expertise. The other forms of undersupply are due, primarily, to the interpersonal heterogeneity in needs within the same categories for which reimbursement is contemplated. If interpersonal heterogeneity is high, then, even though better suited than vouchers, also reimbursement of providers on the basis of market share, thus, remains problematic.

[11] Bowles and Gintis, *cit.* focus on school voucher, but their analysis can easily be extended to the financing of health care organizations on the basis of market share. Notice that, in this case, freedom of choice among providers would have nothing to do with allowing the satisfaction of differences in preferences (matching). On the contrary, it would empower recipients vis à vis providers, even assuming the same preferences (exactly, in the results of being treated and trained).

[12] Throughout the paper, incentives refer to extrinsic financial incentives.

[13] On vertical cream-skimming, see Ellis, 1998 and on horizontal cream-skimming, see Levaggi, Montefiore, 2003.

Finally, competition on quality penalizes the supply of indivisible services, that cannot be sold on the market. A typical example, within health care, is that of prevention.

The negative effects on health generated by overall undersupply are evident. Oversupply, too, may, however, jeopardize health. Within health care, in fact, oversupply does not imply merely waste - health benefits are produced that are inferior to the costs to produce them -, but also health risks, health risks being associated with many treatments delivered. In other terms, oversupply may entail inappropriateness, that is to say, delivery of services to patients for whom the profile benefit/risk is negative for health. While waste does not in itself jeopardize the achievement of results – simply, social welfare is not maximized -, this is not the case for inappropriateness.

These statements may sound simplistic. There is evidence that competition on quality, rather than over or undersupply, may induce improvements in quality, even in those elements less observable by patients. The most striking is that furnished by Kessler and McClellan (2000), who find that risk-adjusted one year mortality from acute myocardial infarction is significantly lower the higher is competition on quality (where competition is measured on the basis of the degree of market concentration). The data are striking since most patients suffering from hearth attack, far from exerting freedom of choice, are taken to the hospitals by the ambulance. As argued by Gaynor (2006, pag.17), this may suggest that "hospitals in more competitive environment are pressured to be better across the board". Positive effects have also been found for dialysis (Held and Pauly, 1983). One possible reason is that doctors are unaffected by incentives. Besides, not all elements of health care quality are not observable (by patients): suffice to think to waiting times, flexibility in the scheduling of appointments, amenities, cleanliness, nature of the human relation entertained with professionals.

Furthermore, in case incentives are at work, antidotes are available no matter what is the specification of the competition on quality. Ultimately, with the exception of the overall incentive to skimping which is intrinsic to prospective payments, what allows oversupply and undersupply (of divisible) services) are shortcomings in the definition of prospective payments, oversupply being possible only if prices are above marginal costs and undersupply being favoured by prices not reflecting the variance of costs. Both risks are also contingent on the remuneration unit: for example, the less the remuneration refers to single services the weaker is the incentives to oversupply. From this point of view, payments based on DRG are superior to fee-for-service, but inferior to payments on the basis of the cases treated.

Finally, the enabling proposal offers some further antidotes unavailable within other versions of competition on quality (indeed, it has been chosen for this reason). Namely, it is centred on non profit organizations, whose structure of property rights weakens the (negative) power of the incentives[14], which translates in personnel policies less influenced by the incentives, as well as on an extensive role of the public sector in the diffusion of information, regulation and control. These factors limit the incentives to over and undersupply.

Regarding the positive evidence, all studies reporting positive effects, even in presence of non observable dimensions of quality, involve treatments for which the risk of inappropriate admission of patients is absent: there is no controversy that a person suffering from acute myocardial infarction or renal failure needs treatment. The case could be dramatically different for specialties

[14] The incentives would be high powered in for-profit organizations, whose first obligation is to stock owners (even though the for profit motive could be contaminated by the mission to treat patients). On high vs. low powered incentives, see the seminal Tirole, 1988. In perfect competition, the allocation of property rights would, instead, be irrelevant, consumers' surplus always being maximized.

such as dermatology, in the light also that doctors' behavior appears influenced by incentives[15]. For what concerns the risk that oversupply endangers health, it seems useful to recollect that doctors tend to prescribe much less for themselves and for their relatives/friends than for the generality of their patients and that errors associated to prescription are diffuse and severe[16].

In addition, especially for acute myocardial infarction, there have been extensive public programs aiming at increasing appropriateness in the process of care and at opposing the risk of undersupply. These programs could, certainly, be realized within the enabling proposal. The question is that improvement may be due mainly to these programs rather than to competition on quality. In any case, there is also ample evidence that public competition may lead to undersupply[17] .

Also for what concerns the observable dimensions of quality, the benefits may be scant, if the average level of professional culture is low. Were this the case, search costs, too, may hamper exit (besides informational failures).

Regarding the definition of prospective payments, competition on quality, to be deployable, needs prices above marginal costs to finance the excess capacity (necessary for allowing choices) as well as improvements in quality. The only exception would be if the incentives from competition lead to a slack reduction sufficient to these goals, but this appears quite unlikely[18]. This means that also the incentive to oversupply is unavoidable, while prospective payments apt to reflect the heterogeneity of patients require information that is unavailable to regulators. Moreover, there is a trade off, in the choice of the remuneration unit, between different finalities: for example, payments on the basis of the case treated may contrast oversupply, at the cost, nevertheless, of stimulating undersupply[19].

Finally, also the special antidotes furnished by the enabling proposal appear wanting. On the one side, the evidence is quite strong that incentives affect also the behavior of non profit organizations[20]. One possible reason lies in the diffusion, within health care, of commercial non profit organizations, the non distributional constraint, as argued by Hansmann (1996a e b), being a rather blunt instrument for consumer protection. The evaluation could be different for non commercial organizations. Besides being scant in the overall economy, the role of these organizations is, however, further circumscribed in high technology sectors, such as health care, requiring high investments in capital and in expertise[21]. Within health care, non commercial organizations tend to be confined to the "softer" niches of long term assistance, self-help, psychological support for specific diseases and advocacy.

On the other side, the diffusion of information, such as that brought about by Reports Cards, may support patients' choices, offering indications on the quality of care delivered. Nevertheless, the non

[15] On the role of incentives on doctors' behavior see, among the manifold studies, Conrad, *et al.* 2002, McGuire and Pauly, 1991, Robinson, 2001.

[16] See, respectively, Domenighetti, 1994 and Kohn, Corrigan, Donaldson (eds.), 2000. On the extent of inappropriateness, see the seminal Chassin *et al.*, 1987.

[17] See, for example, the ample review in Gaynor, *cit.* See also evidence in Ellis, *cit.*, Horwitz, 2005 and le Grand, 2001.

[18] For example, all cases of quality improvements documented by Gaynor, *cit.* are associated with prices above marginal costs.

[19] The more aggregate is the unit, the more remuneration of the providers on the basis of market share becomes similar to vouchers.

[20] On the role of incentives on non profit organizations, see, among the others, Cutler and Horwitz, 2000, Duggan, 2000, Silverman, Skinner, 2001, Sloan, 1998 and 2000, Sloan *et al.* 1998 and Weisbrod (ed.), 2000. For examples of commercial non profit organizations less sensitive to incentives, see Feacherm *et al.* 2002 and Lawrence *et al.*

[21] Compared with for profit organizations, also commercial non profit organizations are penalized in the access to capital, lacking the possibility to resort to equity financing. This is one of the main reason behind the increasing conversion, in the USA, from the non profit to for profit status (Cutler, Horwitz, *cit.*). Compared with the organizations of the civil economy, access to credit market is, however, easier.

observability of all dimensions of performance induces "gaming": showing good performance in the observable dimensions at the expense of the non-observable ones[22]. At the same time, the diffusion of information, such as that on evidence based medicine, has to be accompanied, to be effective, by a coherent organizational design. In the enabling proposal, on the contrary, incentives for suppliers go in the opposite direction and the centrality attributed to freedom of choice, even though constrained by the in-kind transfers, entails the sovereignty of private tastes/preferences, irrespective of any need of justification vis à vis third parties. Even though not directly hampering the diffusion of evidence based medicine, freedom of choice does not favor it[23].

The sovereignty of freedom of choice also circumscribes the chances for extensive regulation of the standard of care. Indeed, the regulation mostly utilized by actual enabling schemes, rather than the standard of care, concerns accreditation and *ex post* undifferentiated cuts (either of prices and/or of quantity), once a given quantity of output has been reached. These cuts risk to bring about further risks of undersupply.

In brief, in health care, the "informative/regulative" public sector, so praised by the supporters of the enabling proposal, may have a hard time ensuring that the incentives put in place go in the desired direction. On the contrary, the risks of jeopardizing the achievement of results are present.

These risks are lower in education, where the quality of services is more easily ascertained and vouchers, involving a bulk amount, do not induce oversupply (in any case, oversupply would not jeopardize the achievement of results). Undersupply is, instead, possible, but touching especially the poor/socially disadvantaged, the question is postponed to the next section.

Irrespective of distributive implications, the introduction of vouchers appears to improve training (Hoxby, 2000, 2001, Hoxby, ed. 2003 and Lundsgard, 2002). This notwithstanding, improvements involve a selected ensemble of performance indicators (reading skill, mathematical problem solving…). Since these indicators are publicly released, for instance, trough League Tables, the risk returns that associated with the Report Card in health care: on the one side, "gaming", in the sense of concentrating the efforts on the indicators utilized and, on the other, errors in evaluation, in the sense that changes in behavior, rather than to vouchers, may have to be attributed to public disclosure of performance indicators[24]. Furthermore, informational failures may also exist in schooling: parents, for example, may value high grades more than the content of education, especially in countries where diplomas have legal value, or, as argued by Barr (2001), may express backward-looking choices, demanding the training for their children they would have desired for themselves, even though outdated. Finally, the same considerations, above developed, on the low chances of extensive regulation in health care apply to the regulation of the curricula.

Public monopoly may have two main overall advantages in the achievement of results. First, it would allow the so-called "demand-management". In this perspective, within health care, public administrators would be responsible for the planning of the overall quantity of final output,

[22] For example, Dranove *et al*., 2003 show that in New York and Pennsylvania, Reports Cards led both to selection behavior by providers and to improved matching of patients with hospitals. On net, besides than to higher expenditure, this led to worse health outcomes, particularly for sicker patients. Overall negative effects are also reported in Chen, *et al.* 1999. This does not mean that Report Cards are undesirable. Simply, the benefits following from disclosure of information may be more difficult to obtain than often assumed.

[23] To this regard, it is interesting to recall the experience, in the USA, of the HMOs (Health Maintainance Organizations). After having registered a rapid increase (contributing to a decrease in the rate of growth of health expenditure), HMOs have experienced a backlash (and the rate of growth of health expenditure has again started to rise). Among the many reasons for this backlash, there are the difficulties, in a system praising freedom of choice, to resort to predefined evidence based protocols of care (as requested by the HMOs).

[24] On the first risk, see Neal, 2002 and Figlio, Rouse, 2005 and on the second, Braun, Jenkins Griegg, 2006.

including indivisible services, and for defining the protocols of care. In compulsory schooling, public monopoly would ease the definition of a common core of subjects to be learned.

Demand-management could be perfectly compatible with some competition on quality. On the one side, within the social services, public monopoly is a quasi-monopoly, social services being produced by a plurality of organizations rather than by a natural monopoly. These organizations, in addition, may include private ones, as in the Italian and in the British National Health Services. On the other, the criticism above developed concern competition activated by recipients' of services rather than competition on quality *per se.* This means that, given the constraints fixed by demand management, public administrators could, for example, contract/cooperate with private organizations for ensuring quantity of care that the public organizations may not be able to provide. Recipients of services could have some freedom of choice, among the public organizations and the selected private ones[25] and public organizations, such as public hospitals, could be given some (limited) incentive to attract recipients: for example, to increase services in specialities at lower risk of inappropriateness where waiting times are deemed unacceptably high.

Second, public monopoly relies on public organizations, characterized, exactly as the non-commercial non profit organizations, by a commitment to the intrinsic value of the services provided, thus, by low-powered incentives (to exploit informational failures). In this sense, contrary to what often said in the public debate, the absence, within public supply, of high powered incentives would have to be valued positively[26]. This would further constrain the risk of negative side effects associated with the partial reliance on incentives above mentioned. Compared with the non commercial non profit organizations, public organizations would, however, benefit from easier access to capital, and would a statutory obligation to the whole of citizenship, rather than to what the particular individuals resorting to them and working in them may happen to desire. Even though inevitably difficult, given the predominance of medical culture, prone to overvalue the benefits of medical acts, this may ease the utilization of evidence based medicine. At any rate, controls would also be easier to administer. In brief, the advantage of public monopoly would lie both in the different rules of the game that may be adopted and in the nature of public organizations.

Finally, comparisons between alternative institutional arrangements should be done assuming parity of costs for the public pursue. The costs of the enabling proposal should not be undervalued. As above argued, prices within public competition may have to be above marginal costs. To this, one has to add the administrative costs to spread information, regulate and control[27] and, in health care, the likely costs associated with oversupply.

Anyhow, eventual gains in productive efficiency associated with private supply would not be enjoyable by the public pursue, the presence of prospective payments meaning that any gain in productive efficiency is enjoyed by the suppliers themselves. The evidence, in any case, does not show robust signs of superiority of the private non profit organizations vis à vis other organizational forms[28]. If public monopoly costs less, comparison should be made taking into account this difference.

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[25] Given the similarity above acknowledged of behavior between for profit and commercial non profit organizations, also the former could be utilized.

[26] On this point, see, for example, Besley, Ghatak 2001, who argue that if the good produced is a collective good like quality, it would be better to entrust its production to the party attributing more value to the investment, and Acemoglu, Kremer, Mian, 2003 (p.5), who argue that "government may be appropriate for tasks where it is difficult for clients to separate accurately true quality from efforts to signal quality".

[27] On the overall costs of regulation, see, for example, Power, 1997. On the costs specifically of educational vouchers, see, Levin, Driver, 1997, according to whom administrative costs may rise up to 25% compared with public monopoly.

[28] Within health care, see for example, Sloan *et al cit.* Some differences in costs are reported in the less capital/expertise intensive sectors, where professional power is weaker and economizing on the cost of labor is easier. This appears to be

3. Distributive equality

With respect to distributive equality, I see three main risks. The first is that the poor/socially disadvantaged are penalized in the achievement of the results. On the one side, the risks shown in Section 2 tend to be concentrated on them. For example, because of further informational deficit, the poor/socially disadvantaged tend to suffer an excess of hospitalisation for services more associated to a negative profile benefit/risks (Epidemiologia e Prevenzione, 2004). This happens also within National Health Services characterized by public monopoly, but the enabling proposal accentuates the risk. In addition, both because of informational deficit and because harder to treat, the poor/socially disadvantaged are at higher risk of skimping and vertical cream-skimming. For example, inducing healthy lifestyles is harder among the poor/disadvantaged and these latter also tend to resort to services at a later stage of the development of the disease when treatment is more difficult. These same reasons may also induce territorial cream-skimming at the expense of the more disadvantaged areas. Skimping and overall cream-skimming, on their part, entail private financial costs, (suffice to think to the costs associated with early de-hospitalisation and/or territorial mobility) harder to bear for the poor/socially disadvantaged.

On the other side, there would the supplementary risk of undersupplying schooling for the poor/socially disadvantaged merely mentioned in Section 2. The risk is here that, while potentially benefiting the more talented/motivated students among the poor/more disadvantaged, educational vouchers penalize the less talented/motivated ones who remain entrapped in the worst school, partly because of informational failures and partly because of vertical and territorial cream-skimming[29]. The result, for them, would not only be the impossibility to benefit from vouchers. It could also be a further worsening in the quality of training, given the associative nature of this latter. Training, in other terms, necessitates a "customer-input technology", the characteristics of the customers themselves generating externalities on the quality of the output, thanks to a peer group effect[30]. The less able/motivated is the student body, the lower is the training available to each student (and viceversa). To this, one may add the demotivation of the teachers remaining in the worst schools.

Again, the enabling proposals offers some antidotes. Within schooling, the less demanding entry requirements could ease the development of non commercial organizations with a strong sense of mission towards the worst off. This, for example, seems to be the case of Catholic schools in the United States[31]. Regulation could also require open access and this latter could be further supported by coherent reimbursement mechanisms. Vouchers could differentiate the amount according to the characteristics of the recipients or even to the overall socio-economic composition of the student body. A voucher from a low income/minority student, for example, could be worth more to a predominantly upper class school than that of another upper class student, as in Netherlands, where some students elicit more than 90% more than others (Lundsgard, *cit.*), thus, limiting cream-skimming. Furthermore, vouchers may cover transportation and, as suggested by Bowles and Gintis

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the case of non profit schools (Lundsgard, *cit,*), that may rely on parents volunteer work and on stronger informal relations between school board and teachers (that decrease administrative costs). More research has, however, to be made, in the light of the heterogeneity of the output. Public hospitals, for example, may cost more because they refrain from dumping/skimping.

[29] This would be exactly the opposite of what is required by the rawlsian *maximin*. Also students coming from more advantaged background may be hard to train, but, in this instance, schools may have more difficulties to acquire the information needed to select.

[30] On the role of peer group effect in education, besides the famous Coleman Report (Coleman, 1961), demonstrating the substantial irrelevance of resources compared with student body composition, see, among others, Epple, Romano, 1998 and 2000.

[31] For evidence, besides Coleman, Hoffer, Kilgore 1982, see Akerlof, Kranton, 2002 and Ladd, 2002.

(*cit.*), lotteries could be utilized in presence of over-demand, to avoid residual risks of cream-skimming. This notwithstanding, the available data are quite unanimous in showing undersupply among the poor/socially disadvantaged, for the students who are harder to train [32].

A public monopoly, through demand management and the low-powered incentives of public supply could cope also with these risks. To this regard, apply the same considerations above developed with respect to the achievement of results: for example, public monopoly is compatible with public administrators selecting some private non profit organizations to be part of the overall network of suppliers.

The second risk is that of cuts in the level of social protection following the increase in public expenditure that may be associated with the enabling proposal. If public monopoly costs less, more resources could be left to redistribution.

I like to conclude this section with a more speculative consideration, pointing at the risk of a weakening of the overall propensity of redistribute, even if no increase in public expenditure is involved. The question has to do with the old concern with public character. As Van Parijs (1995, p.231) cogently puts it, "one can hardly expect the required dispositions to flourish as spontaneous expression of a universal human nature. They will have to be nurtured, preserved, encouraged, engineered into existence by specific social conditions, specific ways of organizing social life"' [33]. If we want to sustain redistribution as a matter of justice[34], it appears essential the sharing of a public *ethos*, characterized by what we may call the egalitarian reciprocity, that is to say, the capacity, when discussing the definition of rights and duties, to take the point of view of others, in the acknowledgement of a common fundamental equality of respect. This does not deny individual interests and special attachments. Simply, means that when assessing what we owe to each other[35], rather than utilizing the singular pronoun I, we "see/filter" our positions taking the point of view of the "we" that each of us could be[36]. The development of this capacity may require public spaces, unavailable within the enabling proposal.

More precisely, the enabling proposal entails public spaces as well as reciprocity. Just to mention questions that would need more in depth study, even the walrasian market of anonymous exchanges has elements of publicity in so far as products and providers may be seen by all[37]. Furthermore, markets, even though populated by entirely self-interested agents, need contracts and overall cooperation, which means acts based on reciprocity. The enabling proposal, in addition, relies on organizations of the civil economy that are intrinsically committed to reciprocity, on the basis of peer relationship, and, even though we have abstracted from it, maintains collective decision making in the overall definition both of in-kind services and of the enabling proposal. Finally, with regard to schools, appropriate regulations aiming at developing the public *ethos* could be introduced in the *curricula*: for example, banning intolerance and prescribing civic education.

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[32] See, among others, Cullen, Jacob, Levitt, 2005, Epple, Romano, 2000, Ladd, *cit.* and Le Grand, *cit.*.

[33] On this line of argument, see also Clarke, 2004a e b for an interesting analysis of the relationship between the exercise of consumers' freedom and the weakening of the public realm.

[34] The requirement would be useless if redistribution is searched for self-interested reasons: for example, to internalize the negative costs of poverty.

[35] The locution is from Scanlon, 2000.

[36] As cogently put by Nagel, 1997, "the question, in brief, consists in establishing whether at the origin of all that we say or think is the first person, singular or plural" (the translation is mine, from the Italian version, pag.11). The reference, to this regard, is to the overall development of the value of public reason, leaving aside the specific configurations it may take. For a summary discussion of this value, centred on Rawls conception and touching that of Habermas, see Larmore, 2003.

[37] On the market as a public space and, more generally, on different conceptions of publicity, see, for example, Geuss, 2003. On the notions of publicity, see also Bifulco, de Leonardis, *cit.*

The point is that visibility is only one dimension of publicity. Another concerns reciprocity. The reciprocity of the market is, typically, the private reciprocity of the *do ut des* of bargaining, in a context where consumers' tastes/preferences are taken as given and agreements reflect the tastes/preferences that individuals happen to have in common, irrespective of any need of justification on the basis of a common equality. In equilibrium, for example, the price a consumer is willing to pay for a divisible good equals the price desired by the provider. The same is often true of collective decision processes, that are also based on bargaining and give rise to agreements where the public interest is nothing else but the subset of the interests individuals happen to have in common[38].

The civil economy adds a notion of reciprocity based on the recognition of a common equality. It is, however, a demanding kind of reciprocity[39] that, being associated with the practice of sociality, involves a notion of good life that some may not share. Moreover, utilizing Putnam's categories (2001), the risk is that such reciprocity be merely "bonding" among similar individuals rather than "bridging" among different individuals. The reason is that to enjoy sociality one has to feel attuned with the others with whom the relationship takes place. It matters who the other is. Thus, it would still remain a private reciprocity: it is exercised if tastes/preferences favor sociality and, in so far as bonding, among those one feels to be on equal standing. It is rather questionable that such a reciprocity may contaminate the overall social relations in the direction of the development of a public *ethos*.

The egalitarian reciprocity of public *ethos*, instead, requires to justify publicly one's one positions to third parties, from a common standing of equality (of respect), and with an inclusive conception of third parties: in the ambitions, the whole of our fellow human beings. It is a reciprocity that has to do with justice (rather than with the *do ut des* of bargaining or with the practice of the good life) and that is inevitably bridging. There is, then, a difference between the private reciprocity of consumers, the private reciprocity within groups committed to a particular conception of the good and the public reciprocity of citizenship. To develop this latter, a public space like the market appears lacking. Public spaces may be needed in the form of publicly owned organizations such as public schools, where students coming from different backgrounds learn to take the point of view of others, interacting with one another on equal standing, no matter who the others are[40]. Again, this does deny any role to private organization. For example, "bridging" private not for profit schools, such as magnet schools characterized by a commitment to a mixed composition of the student body. This role, however, would be integrative and referring only to a subset of private organizations.

The focus has been on the distributive dimension. Rather than for its effects on the propensity to redistribute, a public *ethos* reflecting the equal respect due to everybody could also be praised by those sharing the paradigm of recognition[41]. At the same time, the public *ethos* could also favor the

[38] This latter would be what Goodin, 1996 calls the least common denominator view of public interest. Even if the public sector utilizes the optimality rule for public goods, the optimal quantity would corresponds to the sum of given preferences for a good that all happen to desire (even though in different amounts).

[39] This is the main reason why the enabling proposal includes the overall world of non profit organizations rather than being limited to the civil economy.

[40] Notice the dual contribution offered by the interaction among the different students, in terms both of peer effect and of public *ethos*. On the contribution of public schools to public *ethos*, see Macedo, 2000. The *ethos* of egalitarian reciprocity may also develop in other social services (suffice to think to Titmuss defense of the NHS). Other social services are characterized, however, by different primary goals and their consumption may come later in life, when character is already developed. Apart from social policies, urban design could also play an important role in developing public *ethos*.

[41] On the recognition paradigm, see Fraser, 1997.

effectiveness in the achievement of results (for example, supporting the diffusion of evidence based medicine) as well as help solving some of the trade-offs among freedom below indicated.

4. The promotion of freedom

Even though within the constraints of in-kind transfers, the enabling proposal promotes many freedoms. It promotes welfare/well-being freedoms and process freedoms, involving immunity in the process of choice as well as autonomous participation in this latter, even at the expense of one's welfare/well-being[42]. The freedoms to pursue one's own conception of the good life could be included in both categories of freedom, in so far as the good life is a source of well-being or is pursued for independent reasons, as expression of autonomy. Freedom, moreover, would have an associative dimension, given the option to practice the associative freedoms of the civil economy (and the overall option to participate in the governance of health and educational policy)[43]. The option of sociality, for example, could be an important source of well-being in today's post-fordist world, where many feel increasingly separated from each other (Bruni, Zamagnu, *cit.*). In this sense, the defence just made of the egalitarian reciprocity should not be read as a denial of the value of other forms of reciprocity (the intent was simply to underline the role of egalitarian reciprocity). Freedom, furthermore, would be enjoyed by both recipients and suppliers, free to enter into the market.

This notwithstanding, I see, again, different risks. The first risk is the well-debated one relating to the limitation in the freedom of choice of future adults associated with educational vouchers. The culprit would be freedom of choice of the parents to send their children to schools committed to specific conceptions of the good life and the freedom jeopardized would be autonomy. The assumption, here, is that autonomy, as the public *ethos*, far from developing in a *vacuum*, requires being supported and this may occur only in a context allowing the confrontation among different conceptions of the good life. Regulation could offer some remedy, requiring, for instance, that, whatever creeds the parents may adhere to, students be exposed to a plurality of view points against the risk of sectarian education or, even, as suggested by Brighouse (1999) mandating an autonomy-enhancing curriculum. As already argued, the likelihood that this happens in a context centred on recipients' freedom of choice appears circumscribed.

Also other two risks are quite acknowledged. One is that of interfering with the overall process freedom of the poor/socially disadvantaged, who, in the light of the risks of undersupply, may *de facto* be constrained to resort to non commercial organizations, committed either to specific conceptions of the good life or to charity (Sennet, 2004). The other is the opposite risk of interfering with well-being as well as process freedom of the individuals operating in the non profit sector, if extensive regulations and control are put in place (Ascoli, Ranci, a cura di, 2003).

Finally, there are two more undervalued risks. The first has to do with the lack of the option of public employment for individuals with a public service motivation (Francois, 2000), who may want to be assured against the risk of exploitation (of this motivation) by commercial non profit organizations, but do not share the conceptions of the good pursued in the non commercial sector.

The other has to with the obligation to pay for services that are consumed by some and that one may not desire. For example, within health care, some may consider high-cost services lengthening life for a few months as waste and others may disagree. Some may consider even the expansion of

[42] On this distinction among categories of freedom, see Sen and, among his many works on the topic, Sen, 1999.

[43] The plurality of these freedoms represents the reason for referring, in the paper, to recipients rather than to consumers, as argued in footnote 3.

freedom of choice of providers and, with it, excess capacity as waste and some may, again, disagree. The same is true for desires such as that of being reassured (and thus, perceiving well being) from the mere act of consuming, even though the effects are unproved. Within public financing, all would have to pay, with the consequence that some individuals would have to give up some freedoms to utilize their income to finance the costs imposed by the preferences of others.

This is, obviously, an intrinsic problem in collective decision-making. In addition, as well known in the literature on the measurement of freedom, the expansion of some freedoms always corresponds to a reduction in some pre-existing freedoms and there is no univocal way to determine whether the overall result is more or less freedom as epitomized by the contrast between the cardinal and the preference-based views of freedom[44]. In this sense, it is still possible that the enabling proposal be considered as having a net positive balance in terms of freedom vis à vis the constrains put by public monopoly.

The point is that the defenders of enabling proposal tend to undervalue these costs, assuming that the introduction of freedom of choice within publicly financed services is a win-win solution, exactly as it happens in competitive market for (excludable) goods. The difference is, however, profound. In these markets, the cost of choice is borne entirely by the choosers. Within social policies, it is shifted on to the whole community.

At the same time, many of the freedoms promoted by the enabling proposal appears perfectly pursuable within public monopoly. Within public monopoly, it is not only possible not to resort to services or not to produce services in contrast with one's conscience[45]. As discussed in Section 2, within the constraints fixed by demand management, it is possible for recipients to choose among providers, including some private ones (which means that also the freedom of potential private entrepreneurs could be ensured, both of those more interested in market-like freedom and in the associative values of the civil economy). Moreover, within the chosen protocols of care, freedom of choice of the treatments may be allowed: for instance, when alternatives options are available with different benefit-risk profiles for the patients as in the choice between a surgery that may leave some impairment or chemiotherapy/radiation in presence of a given cancer, or between repair or substitution in presence of a broken cardiac valve. In so far as bridging, even the demanding reciprocity of the civil economy can be pursued within public monopoly, since public servants may also have this motivation. Finally, albeit decision-making processes are outside the scope of the paper, public monopoly, especially in the areas where less technical expertise is required, could rely on participatory/deliberative practices, where republican freedoms and, also at this level, the associative freedoms of the civil economy can be pursued.

All this considered, the charges often addressed to public monopoly of being inescapably paternalistic and contrary to empowerment, of inescapably operating under a mechanism of command and control, treating all individuals as passive recipients of care, as pawns rather than queens[46], appear wholly out of target. The same is true of charges of a uniformity insensitive to individual differences[47]. Public monopoly may, instead, accommodate many demands of empowerment.

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[44] For a review of these questions, see Balestrino, Carter (a cura di), 1996, List, 2006, Steiner, 2003.

[45] If this does not happen, it is not because of monopoly, but because of external reasons. For example, in the Italian Health Service, individuals are obliged to consume life-saving services even if condemned to a vegetative status. But, this has nothing to do with monopoly. For an example of allowing, instead, freedom not to produce services in contrast with one's conscience, see the freedom allowed to the doctors, again in the Italian National Health Service, not to practice abortion.

[46] The reference is here to the terms in Le Grand, 2003.

[47] Uniformity of treatment may, nevertheless, remain desirable to reflect equal respect, while diversity in treatment may reflect unjustified favoritism.

In any case, it is worth recalling that in context such as that of health care, freedom of choice seems to figure quite low among the objectives sought by patients. The main reasons lie in the time, error and psychic costs of choice[48].

Conclusions

To underline risks of the enabling proposal and possible benefits of public monopoly does not imply the automatic defence of this latter. On the one side, evaluation depends on the sector of social policy. If informational failures, heterogeneity in needs, peer effects, exigencies to develop public *ethos* play a minor role, the enabling proposal may receive a more benign evaluation[49]: the public interest could be satisfied by privately owned organizations operating on the market. Public supply may still be available to cope with some of the risks highlighted, but as one productive organization on the market, among the others.

On the other side, even in sectors where public monopoly appears theoretically desirable, empirical contingencies may lead to opposite conclusions. The paper has focused on the risks of enabling proposal. The possible costs of public monopoly are, however, well known. For example, the negative side effects of low powered incentives of public supply could be slack. Public schools could perfectly reflect residential segregation and patients could be treated in a public hospital with less respect than in a charity. In this situation and if improvements are considered impossible to realize, the enabling proposal could be a second best option (even though the quality of public servants remains crucial also for the success of this proposal).

This could be disturbing to economists searching for univocal answers, but once we leave the easy world of perfect competition, the results (the performance) of different institutional arrangements are wholly contingent on the nature of preferences of the individuals working in them and on larger institutional context in which the arrangements are set. Still, no matter what is the quality of public supply, some may prefer the freedoms promoted by the enabling proposals at the expense of the risks associated to it.

In addition, to underscore a possible space for public monopoly is only a first step which needs to be followed by a more detailed analysis of the design of public monopoly itself. The theme was out of the scope of the paper, even though some indications are offered also to this regard. For example, if one of the advantages of public supply are low-powered incentives, to move towards a more commercial design, as suggested by the so-called New Public Management, may contemplate many drawbacks. On the contrary, more attention should be given to reassurance mechanisms aiming at strengthening public sector motivation[50]. Moreover, if the egalitarian reciprocity has the ambition of potentially including everybody, state rather than regional schools appear preferable, even though acknowledging the contingent[51] and far from inclusive character of the state itself.

This notwithstanding, it seems important to define the broad pictures of the options facing social policy. To this regard, entering into the still too little explored space of the correspondence between

[48] On the costs of choice in health care, see Gori (a cura di), 2005 e Hanoch, Rice, 2006. For some extensions to other social services, see Lowenstein, 1999 and Mann, 2006 and, more in general, see Beltrametti, 2004, Elster, 2000 and Schwartz, 2004.
[49] For a taxonomy of possible cases, even though valued on the basis of fewer criteria than the ones here utilized, see, for example, Blank, 2000.
[50] On this, see, for example, Besley, Ghatak, *cit.* and Frey, 1997.
[51] On this, see the cogent analysis in Bruni, Zamagni, *cit.* centred on the role played by the Westphalia Treaty.

values and institutional design, the paper has tried to challenge, theoretically and relying on empirical evidence, easy connections between public interest and public provision. Focusing on a conception of public interest which appears widely shared – in so far as committed both to distributive equality and to freedom of choice – and on a design of public provision, like that of the enabling proposal, which appears relatively robust to satisfy this goal, it has highlighted the different ways through which, within health care and compulsory schooling, public provision risks jeopardizing many dimensions of the public interest. Public provision could jeopardize the achievement of results crucial to all to purse one's life plan, no matter what this is. This risk is higher for health care, because of the incentives to oversupply services that may damage health as well as to undersupply others useful for health, but it exists also for compulsory schooling. Public provision could also have negative distributive implications, because the risks of non achieving the results tend to be concentrated within the poor/socially disadvantaged; the cost of the proposal may lead to overall cuts in redistribution and the overall propensity to redistribute may result weakened. Finally, public provision may even violate some dimensions of freedom.

Public monopoly may, instead, exhibit advantages thanks to demand management; reliance on low powered organizations, as such, scarcely motivated to exploit recipients informational failures and to search for the most remunerative recipients; capacity for saving compared with more decentralized contexts; availability of a public space where different individuals can interact from a standpoint of common equality, thus favoring distributive equality and, again paradoxically, the possibility of promoting freedoms that could be jeopardized in the perspective of the enabling proposal. It may, also, satisfy many dimensions of freedom promoted by the enabling proposal.

If this is the case and if public monopoly in health care or in compulsory schooling is the *status quo*, one has to be quite cautious before proceeding towards changes as those envisaged by the enabling proposal. Since a great deal of theoretical considerations and significant empirical evidence militate against this proposal, those supporting it should demonstrate its superiority, before changes be started. Which, by the way, is exactly the opposite of what is required by the subsidiarity test, according to which existing public organizations have first to prove their superiority compared with an hypothetical world dominated by private action! At the same time, the awareness of the potential benefits of public monopoly should alert against the risk of policies progressively contributing to the de-qualification of public monopoly itself. At the end, de-qualification may be the result and the enabling proposal may become the second best solution. Far from deriving from intrinsic shortcomings of public monopoly, this result should, however, be attributed to the (ir)responsibility of public policy.

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