

## 8. THE CHANGING BALANCE BETWEEN PUBLIC AND PRIVATE WELFARE

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### 1. Introduction

This paper is concerned with giving an empirical content to some ideas about the structure of welfare activity originally advanced by Richard Titmuss in a lecture which he gave over forty years ago. He talked then about the “social divisions of welfare”, and pointed out that looking simply at “the welfare state” omitted important parts of welfare provision, notably “fiscal welfare” supported by tax reliefs, and “occupational welfare” provided by employers.<sup>2</sup> The paper also looks at some of the economic arguments which explain the boundaries between such sectors.

The different treatment of and attitudes towards those benefiting from different forms of welfare were key aspects of social policy, then, and such issues remain central to British politics. Indeed, politics is now dominated by questions around social policy, while many of the central questions in social policy relate to the respective roles of the state and the market, and to the appropriate balance between public and private sectors within welfare activity.

This is not just a matter of debate between British political parties, it is also highly contentious within them. In April 1999, the then Deputy Leader of the Conservative Party, Mr Peter Lilley, delivered a memorial lecture to RAB Butler,

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<sup>1</sup>This paper is based on the Richard Titmuss Memorial Lecture, given at the Hebrew University of Jerusalem, Israel, May 1999. It draws very heavily on joint research with Carol Propper, reported in Burchardt, Hills and Propper (1999).

<sup>2</sup>Titmuss (1963).

who had reconciled his party in the 1950s to many of the welfare institutions established by the 1945 Labour government. The intention of Mr Lilley's speech was to dispel in the public mind the idea that the Conservatives had an agenda of privatising key parts of the welfare state like the National Health Service or state education. In the course of his discussion of the limits to the applicability of markets he argued that his party had to renew public confidence in its commitment to the welfare state, "But we will only do so if we openly and emphatically accept that the free market has only a limited role in improving public services like health, education and welfare".<sup>3</sup>

This might not seem a particularly contentious statement, but all hell broke loose within the senior ranks of his party. Perhaps tactlessly, he was attempting this repositioning of the Conservatives in the public mind on the same evening that a grand reception was being held to honour the twentieth anniversary of Mrs Thatcher's first election victory in 1979. The public row with those who wanted to hold firm to what they saw as the privatising tenets of Thatcherism did little to help his party in the middle of the campaign for local, Scottish and Welsh elections. Mr Lilley lost his job two months after the speech.

But this kind of debate is also central to the politics of the new Labour government. Disappointing some of its more traditional supporters, it did not embark after its election on a wholesale expansion of public welfare spending. Indeed, a key part of its election campaign had been to pledge to keep to its predecessor's very tight plans for public spending for its first two years in office. At the end of those two years it has now embarked on a programme of significantly increased public spending on health and education, and there have already been substantial increases in spending on welfare to work measures – the so-called "New Deal" – and in social security benefits and tax credits for families with children.

But this expansion of universal welfare services has been selective. In its proposed pension reforms, the Government has set out the aim that the balance in provision should move from being 60 per cent public and 40 per cent private

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<sup>3</sup>Lilley (1999), p.2.

now to the reverse proportions over the next fifty years,<sup>4</sup> while its extra spending has been on means-tested benefits for pensioners, not on the universal basic state pension. In its overall description of its aims for welfare reform published last year, it listed eight principles which would guide reform, the second of which was that, “The public and private sectors should work in partnership to ensure that, wherever possible, people are insured against foreseeable risks”.<sup>5</sup> It has conspicuously failed to rush to endorse the recommendations made in March for increased public spending from a Royal Commission which it had established itself to look at the provision of long-term care for the elderly.

## 2. Boundaries between public and private welfare in the UK since 1979

Does this “selective universalism” on the part of “New Labour” and soul-searching within the Opposition mark a departure from the Thatcher years? After all, one of the defining characteristics of Thatcherism was its belief in privatisation, and it is not hard to find examples within each of the main welfare sectors:

- Within **education** the Conservatives introduced an “Assisted Places Scheme” (since abolished) under which the government paid for some pupils to attend private schools.
- Within **health** there were tax concessions for private medical insurance for the elderly, and overall coverage rose from 2.5 million people in 1979 to nearly 7 million in 1990,<sup>6</sup> more than a tenth of the population.
- Within **housing** more than one and a half million publicly-owned council houses – a quarter of the 1979 stock - were sold to their tenants under the “Right to Buy”, and owner occupation rose from 55 per cent in 1978 to 67 per cent in 1995.<sup>7</sup>

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<sup>4</sup>DSS (1998b).

<sup>5</sup>DSS (1998a), p.2.

<sup>6</sup>Burchardt et al. (1999), p.6.

<sup>7</sup>Hills (1998), pp.152-3.

- Tax concessions were also given to encourage more people to opt out of state **pensions**, and the number with personal private pensions (not provided by employers) doubled from three to six million between 1987 and 1992.<sup>8</sup>
- Within **personal social services**, the proportion of long-term residential care places for the elderly provided by local authorities fell from over 60 to under 30 per cent of the total between 1983 and 1995.<sup>9</sup>

These kinds of trend certainly give an impression of a growing role for the private sector across the board and of a successful “rolling back” of the welfare state. But one has to be careful. First, public spending on the main welfare services was almost exactly the same proportion of national income – just under a quarter – in the Conservative’s last year in office, 1996-97, as it had been under its Labour predecessor twenty years before.<sup>10</sup>

Secondly, the items we have just described are very heterogeneous. Owner-occupation has grown, but part of this is publicly financed through tax-reliefs. Private residential care places for the elderly have grown, but much of this is also publicly financed. By contrast, most of the expansion in private medical insurance was carried out without tax concessions. What kind of activity is “public” and what is “private” is less distinct than might be thought at first sight. To cope with this, we, with Carol Propper, have developed a framework for analysing public-private roles according to three dimensions:<sup>11</sup>

- **Provision:** is the provider a public or private sector body?
- **Finance:** does the public sector pay for the service either directly through subsidy or indirectly through benefits or tax relief?
- **Decision:** can individuals choose for themselves the provider used or the amount of service?

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<sup>8</sup>Burchardt et al. (1999), p.7

<sup>9</sup>Ibid., p.8

<sup>10</sup>HM Treasury (1998) and earlier equivalents.

<sup>11</sup>See Burchardt (1997) and Burchardt, Hills and Propper (1999) for more detailed discussion.

This three-way classification generates eight possible combinations, illustrated in the diagram shown in Figure 1. The sectors in the top half of the circle are publicly provided, those on its right hand side are publicly financed, while those in the inner circle are under public decision. Taking each sector in the top - publicly provided - half:

- Inner right quadrant: the “pure public” sector, with public finance, provision and decision; for instance child benefit.
- Outer right quadrant: publicly financed and provided services, but with private decisions on whether to use them; for instance, payments into second-tier state pensions (which can be opted out of).
- Inner left quadrant: services which are publicly provided and decided upon, but financed privately; for instance, rent paid individually (without support from state benefits) for a council house.
- Outer left quadrant: publicly provided services, but with private finance and decision; for instance “pay-beds” used by private doctors in NHS hospitals.

Correspondingly, those in the lower half are privately provided services:

- Inner right quadrant: publicly financed and controlled services from private providers; for instance, Housing Benefit payments to tenants of non-profit housing associations.
- Outer right quadrant: publicly financed services from private providers with private decisions; for instance, tax reliefs for mortgages or pensions.
- Inner left quadrant: privately financed and provided services, but with public decisions; for instance, payments from absent parents for child support.
- Outer left quadrant: the “pure private” sector, with private finance, provision and control; for instance, unassisted places at private schools.

Using this typology, we can chart the changing welfare mix in recent years.<sup>12</sup> What is immediately striking is how different the welfare mix is between sectors, and how the trends within them differed over the Conservative years. For instance, Figure 2 shows what has happened to *education*, the heights of the bars representing the percentage of all education activity in each sector. The striking change is the fall in the “pure public” sector from nearly two-thirds to just over half of the total. The “pure private” sector more than doubles from 8 to 18 per cent, driven by growing private spending on things like driving lessons and leisure courses as well as university fees paid privately, and greater spending on private schools.

Within *health* services, Figure 3 shows that the pure public sector remains dominant, but even in 1979-80 private provision of publicly financed and controlled services represented 18 per cent of the total. The biggest part of this (lower inner right) sector are general medical services provided by family doctors (GPs). The pure private sector almost doubles from 9 to 15 per cent, with rapid growth in both spending on over-the-counter medicines, spectacles, etc., and on private medical insurance. Other sectors grow, but actually remain relatively small, like tax relief on private medical insurance (lower outer right).

Of all the services, *housing* started in 1979-80 with the largest pure private and smallest pure public sector (Figure 4). With growing owner-occupation and some revival of private renting, the pure private sector provided more than two-thirds of all housing in 1995-96, measured in terms of its annual rental value. In both years, public finance for private housing under private control – tax reliefs and housing benefits – represented another sixth of the total. Most strikingly, by 1995-96, the pure public sector – council housing paid for through subsidy and benefits – represented only a tenth of all housing provision.

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<sup>12</sup>For details, see Burchardt et al. (1999), Table 1 and Burchardt (1997). Figures for publicly-financed items are generally based on Departmental annual reports and other official series, supplemented by data from contributions to Glennerster and Hills (1998) for each service area, and estimates for the value of tax reliefs, drawing in part on the work of Sefton (1997) on the value of the “social wage”. Figures for privately financed activity use industry sources and data from surveys such as the Family Expenditure Survey. The figures for housing relate to the annual rental value of the housing stock, including imputed rents where relevant.

In contrast, the pure public sector actually grew within *income maintenance and social security* to two-thirds of the total (Figure 5). With growing unemployment and other forms of non-employment the real cost of non-pension social security doubled, and spending on the basic state pension grew with ageing. With more contracting out of state second-tier pensions, there was a switch from the upper to lower outer right sectors. The pure private sector (mainly pensions) grew in real terms, but fell as a share of the total as the public sectors expanded faster.

Finally, Figure 6 shows the way in which “contracting-out” of services took the share of *personal services* in the pure public sector down from 70 to 41 per cent of the total.<sup>13</sup> Correspondingly, the lower inner right sector – containing items like local authority spending on contracted out residential care and social security benefits paid for residents of independent care homes – grew from 11 to 34 per cent.

As these charts show, what happened to welfare activity in Britain under the Conservatives was far more complicated than might have been expected from a simple model of “privatisation”. There was a relative decline in the “pure public sector”, and a rise in the “pure private sector”. But there were exceptions to this – the increasing importance of general social security – and important changes in some of the “mixed” sectors in particular services.

The changing overall welfare mix is shown in Figure 7. What this brings out – perhaps surprisingly – is how gradual the shifts were over this period. Welfare activity was *already* very mixed in its composition in 1979-80, with the pure public sector only making up 52 per cent of the total. This fell, but only to 49 per cent in 1995-96. Meanwhile the pure private sector did increase significantly from 24 per cent, but still only to 29 per cent. Some of the trends seen within services shown in the earlier figures offset each other, as does the changing relative size of each. The general shift away from the pure public welfare state seen in education, health, housing and personal services is mostly offset by the growing real value of state-provided and financed social security.

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<sup>13</sup>This excludes informal care by relatives, etc., because of the difficulties in putting a meaningful monetary value on the time and energy of informal carers.

Perhaps the clearest message from the figure is that the effect of “privatisation” was more to raise the importance of the bottom half of the diagram – private provision, which rises from 41 to 49 per cent – than that of the left hand side – private finance, which rises from 27 to 31 per cent.

Table 1 compares the scale of total public finance and public provision with overall welfare activity, also showing conventional measures of “public spending”. As a share of national income, public finance grew from 24.0 to 27.7 per cent. This was a rather larger increase than in “public spending” (from 23.3 to 25.6 per cent of GDP over this period), reflecting the greater use of tax reliefs over the period (as well as some definitional differences) – Titmuss’s “fiscal welfare” is still expanding. Meanwhile – despite the trends discussed above – public provision still increased as a share of GDP, although private provision increased much faster. As a result overall welfare activity grew from 33 to over 40 per cent of GDP – more than three times the increase as a share of GDP of conventionally measured public spending on welfare.

### 3. The balance between public and private sectors

These patterns are not straightforward, and nor are those in other countries. Looking across OECD countries,<sup>14</sup> the following broad patterns emerge in the balance between public and private sectors in terms of provision and finance:

- In *education*, state schools predominate in most countries, but there is a wide variation in the role of private schools, and in some countries they are the majority provider. By contrast, the role of private finance, at school level at least, is much more restricted.
- In *health care* public finance dominates, representing more than 65 per cent of the total, except in the USA. Systems of provision vary, but those with mainly private providers are amongst those spending the greatest share of GDP on health care, raising efficiency questions.

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<sup>14</sup>For further details, see Burchardt et al. (1999), section 6. The data used are mostly taken from OECD and World Bank sources for a varying number of countries.

- In *housing*, direct public provision is rare and the UK is unusual in having so much of its stock publicly-owned. However, both direct and indirect public finance makes an important – but minority – contribution to the cost of housing in most countries, through a wide variety of routes.
- Looking at *pensions*, the role of public and private sectors varies widely, although within Europe the UK is unusual in the state not being dominant. Other forms of private insurance for income loss or redistribution are generally small scale, but private savings as a whole make a significant contribution in most countries.

Summarising further, there is a general picture in industrialised countries of the state being the dominant source of finance but not necessarily provision for much education, and of it being dominant in both finance and provision for health care, and for some kinds of social security. Its role in other respects is much more varied.

These patterns are not a simple product of ideology, with one group of countries favouring state-provided and financed services across all parts of welfare activity while another group favours purely private provision with a minimal state role. Most industrialised countries, like the UK, have a welfare mix which is not captured just by looking at the share of national income devoted to social spending; patterns vary between welfare services; and the distinction between provision, finance, and control is clearly an important one.

But why should the state be involved at all? Many important areas of consumption are managed with very limited state involvement. Efficiency arguments in favour of private provision and private payment hold sway over much of Western economic life. Amongst those most often advanced are:

- Decentralised decision-making by consumers allows them to choose the combination of goods and services which best suits their needs and preferences, rather than decisions being taken for them by others.
- Competition between profit-seeking providers leads to provision by the most efficient and most responsive to consumer preferences.

- The market mechanism results in consumers and providers making decisions on the basis of the marginal costs of the resources their decisions lead to the use of, unlike subsidised or state-provided services.
- In reality, the public sector does not operate in the way it is intended to – “government failure” occurs when bureaucrats make decisions in their own interests, exploiting the monopoly power of the state (for instance, to maximise the budgets or staff which they control, or to have an easy life).

For some – including one of the current factions within the British Conservative party – the arguments in favour of private markets are overwhelming, and lead to a presupposition in favour of the private sector in almost all circumstances. In particular, if the sole aim of state involvement in welfare is seen as to do with distribution, the arguments in favour of markets suggest that this should be achieved in cash – through establishing a benefit system aimed at poverty relief – rather than through the provision of services in kind.

Against this, a variety of motivations have been advanced for state involvement in welfare, the strength of which vary from sector to sector:

- Relief of poverty and redistribution towards the long-term poor.
- Redistribution towards groups with particular needs – such as for medical care, disability, or family circumstances.
- Insurance against risks like unemployment or family breakdown.
- Smoothing out income over the life cycle, acting as a kind of savings bank between periods of high earnings and others of education or retirement.
- Ensuring minimum levels or more generally encouraging certain kinds of consumption which have “external” benefits to others beyond the people directly involved (for instance, education).
- Providing particular services collectively where private provision would be inefficient and expensive.

- Promoting social solidarity (or countering social exclusion) by ensuring that everyone is treated in certain respects in the same way.

These motivations can in turn be related back to notions of equity and efficiency, although they cannot be so neatly divided between them. The first and second are respectively about “vertical equity” (reducing overall inequalities) and “horizontal equity” (evening out between those with different circumstances). The third – provision of insurance – is also about equity (compensating the unlucky), but also exists as a state function because of *efficiency* problems with the private insurance market. The next three motivations lie in market failures of one kind or another: capital market failure (for instance, the problems of borrowing against future earnings); the lack of allowance for externalities in private market decisions; and a collection of other reasons, such as economies of scale in provision and the problems of monopoly. The final motivation goes beyond the strictly economic, although it is often argued that universal services deliver a better standard of provision to the poor thanks to pressure from middle-class consumers, which relates back to arguments of vertical equity.

State involvement – and in particular the form it takes – may reflect more than one of these arguments at once. For instance, governments encourage and provide education both for efficiency reasons – encouraging economic growth – and equity reasons – attempting to eliminate some of the low incomes which result from low skills. Even if there is a case for state involvement, there is, of course, a variety of instruments which may be appropriate: direct provision; subsidy to private providers either directly or through tax concessions; or regulation to control quality, prices, or access.

While the main objective of welfare states is often seen as distributional, it is hard to understand the form they take without taking account of efficiency arguments, where the state steps in with the intention of correcting “market failure”. For most welfare services, the key issues surround the problems of private insurance markets and of “externalities”. Much of what the welfare state does is to help people or compensate them if they have problems like ill-health or unemployment. Why cannot these be coped with by private insurance, leaving people to choose their own level of cover and make their own trade-offs in terms

of the risks they protect against and those they take for themselves? Problems of insurance markets include:<sup>15</sup>

- Difficulties in assessing the probabilities of claims: private insurance finds it hard to cope with “uncertainty” as opposed to quantifiable risks. This is important for areas like health and social care needs in old age (as people would generally only have the resources to pay insurance premiums well before the risks would occur, but when it is hard to assess their size).
- If the risks facing individuals are linked, insurers cannot “pool away” the risk to give a secure investment as they can with other forms of insurance. This is important for risks like unemployment or for future medical or care needs (where medical advance may affect what happens and what treatment is possible for all of us).
- If people know more about their own risk status than insurers, only “bad risks” may seek cover, leading to poor value premiums for average cases – the “adverse selection” problem.
- Both public and private insurers have to guard against “moral hazard” – changed behaviour by those with insurance, which raises the costs of protection.
- Insurance products – especially where a lot of marketing is involved – involve administration costs and profits for insurers, adding to premiums beyond the simple cost of the risks covered.
- Where a variety of products is available, consumers can face considerable decision and information-gathering costs, or face the possibility of mistaken purchase (or non-purchase).

The combination of such problems can make private insurance an expensive option. In the UK typical “mortgage payment protection” insurance against unemployment – a relatively simple product – costs more than twice as much

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<sup>15</sup>See Burchardt and Hills (1997) and Barr (1998) for further discussion.

as the actuarial value of the risk being covered, while the combination of lack of reliable data and uncertainty about future medical advance make it virtually impossible for consumers (or for that matter insurers) to assess the value for money of available long term care insurance policies.<sup>16</sup> Related arguments have been advanced to explain some of the very high costs of the private insurance-based US health care system, despite the fact that it does not offer complete coverage of the population.

A second set of arguments relate more to factors which private market decisions may ignore – “externalities” in the jargon of economics. These most obviously apply to state intervention in the case of education, but have also been used to justify housing policies which ensure a minimum standard of housing for all, rather than allowing slums to emerge or children to grow up in very low quality housing, and as one of the arguments for comprehensive health care systems.

In addition, much of the structure of welfare systems as we observe them reflects attempts to minimise the *inefficiencies* coming as a side-effect of other forms of intervention. Where services and their financing are redistributive, those with high incomes will tend to be net losers and those with low incomes net gainers. Whether this is achieved by means-testing and targeting or through the combination of universal provision financed by progressive or proportional taxation, the effect is the same. Somewhere there is a range over which people’s net incomes grow more slowly than their gross incomes. Such effects may distort other kinds of decision – creating labour market disincentives, for instance. The UK’s social security system already embodies a considerable degree of means-testing. One constraint on moving other kinds of welfare provision onto a means-tested basis is that this would widen the income ranges over which acute problems like the so-called “poverty trap” and “unemployment trap” apply. The same issue arises with proposals to switch from universal services in kind to greater redistribution of cash incomes to allow poorer consumers to buy their own health care or education.

A prime difference between many public welfare services and those fully in the private sector is, of course, the way they are paid for, and hence in their

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<sup>16</sup>Burchardt and Hills (1997), Chapters 4 and 6.

distributional effects. The scale of this can be seen by comparing the amounts which people in different parts of the income distribution might be expected to pay for a publicly-financed service through taxation or for a private service through charges. In the former case the cost largely reflects income, in the latter it reflects consumption of the service in question. If consumption is the same for everyone, those with low incomes gain from tax-finance, while those with high incomes lose. This is complicated if use is concentrated more on some groups than others, for instance, in the UK higher education is used more by those with high income backgrounds, while public health care is more used by those with low incomes.

As an illustration of the scale of these differences, Figure 8 shows recent official estimates of the distribution of welfare benefits in cash and kind received by each income group in the UK in 1995-96, and of the taxes required to pay for them (taken as the required proportion of total taxes).<sup>17</sup> For the bottom three-fifths of the distribution, welfare benefits are greater than the taxes they pay towards them; for the top two-fifths the reverse is true. While taxes themselves are generally proportional to income, the net effect of the combination of welfare services and the taxes which pay for them is highly redistributive. This is even though many of the services involved are “universal” in nature rather than means-tested. Moves towards private payment – through charges for services used or private insurance with risk-related premiums – for even small parts of the welfare package could have dramatically regressive effects.

In looking at these kinds of explanation for the role of the state the efficiency arguments in particular vary from sector to sector, and in ways which are reflected by the differences in the patterns of public and private roles in Britain and elsewhere. For some areas of welfare activity – notably insurance against risks like unemployment and family breakdown, and provision like health care – the efficiency arguments combine with those of distribution to favour public provision as well as public finance. In others, the arguments favour both extensive use of public finance and public control in the sense of minimum standards (achieved through compulsion to attend school or to accumulate a minimum level of pen-

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<sup>17</sup>Based on ONS (1997), p.29.

sion, for instance), but leave a less clear-cut choice between public or private providers.

#### 4. Understanding public-private welfare boundaries

Much of the debate around the future of welfare counterposes two distinct sectors: the traditional “welfare state” provided and controlled by the public sector, paid for from taxation; and the private sector, where people buy and sell similar services independently of the state. State hospitals and schools are on one side; private medical clinics in Harley Street and schools like Eton on the other. Corresponding to this there are supposed to be two distinct classes: those who use the state for all their welfare needs and those who have opted out of using state services, and are potentially hostile to further spending on state welfare. Indeed, this stratification was a central part of Titmuss’s idea of the “social division of welfare”.<sup>18</sup>

However, this kind of segregation between public and private sectors and welfare users is not so visible in the UK of the 1990s. Of the 40 per cent of UK national income accounted for by welfare activity, half is *provided* by the private sector, even though more than two-thirds of the total is paid for through public *finance*, either through direct payments or through tax reliefs. The rate of growth in the period of Conservative government in services which were privately provided but publicly financed was almost as fast as that in the purely private sector. The proportion of all welfare activity accounted for by the pure public sector has fallen to just under half – but only just over half was in this sector to start with.

Nor does recent survey evidence of who uses private welfare support the idea of a cut-off and distinct “private welfare class”.<sup>19</sup> It is true that those using archetypal private services such as private health care, medical insurance, or education in Britain do tend to have higher incomes, higher status occupations, and more conservative political attitudes. But the correspondence between such factors is far from exact.

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<sup>18</sup>Titmuss (1963), p.53.

<sup>19</sup>Burchardt and Propper (forthcoming), using data from the British Social Attitudes Survey and British Household Panel Study.

It is also true that those using one private service are more likely to use another, but the proportion of private users who also use all the other private services available is small. Nor is use of a particular service exclusive. Those using a private service in one year are more likely than others to do so the next. But there is also a flow from private use to use of only public services. Many people use combinations of public and private services, even for the same item: as many of those with private medical insurance as those without it visit their state-funded family doctor or are NHS hospital outpatients. Many children who use private secondary schools attended a state primary school, and even more go on to a state-funded university.

This kind of evidence suggests that people's reasons for using private welfare services are generally much more pragmatic than ideological. Few people use exclusively private services; few are wedded to the idea of either only public or only private provision. As in any other market, given the particular structure of and constraints on what is available from the state and the private sector, people make decisions which best meet their own preferences given what they can afford. In this, the way in which the state provides its services is crucial for what one observes in the private sector.

Figure 9 shows a stylised representation of some common situations.

- **(a) No state provision.**

The first panel illustrates the amounts people would buy of a particular service given their income in the absence of any state provision. The higher people's income the more they tend to buy, but there is a range (shaded) for any particular income level between those who value other items more or less. This would be the situation for forms of consumption like food or clothing, where most people choose what to buy themselves.

- **(b) Private additions to state provision.**

In this case the state provides a universal flat rate service of the same value to all, but people can add to it privately. For those who would have bought less than this in the absence of state provision that is the end of the matter. Those who would have bought more add what is effectively a private top-up

(the shaded area) to bring them to the level they would have chosen anyway. The effect of state intervention is to set a minimum level of provision below which people do not fall. British examples of this are private additions to the basic state pension, or most private medical services - these usually add speed or quality to treatment, but do not replace the basic services available from the NHS, which continues to provide the bulk of expensive treatment.

- **(c) Private services as a niche market alternative to state provision.**

A rather different case is shown in the third panel. Here those using the private sector have to do so instead of using the flat rate state provision. This does not affect those who are brought up to the minimum, but creates a rather different position for those who would otherwise have chosen more than the flat rate amount. To increase the amount of the service received they have to purchase the whole amount from the private sector. For those who would only have opted for a little more than the flat rate amount, this large amount of extra spending only to increase consumption by a little will not be worthwhile. They will stay with the state, ending up with less of the service than they would have done in its absence. Only where there is a large difference between the value people put on the state service and what they would otherwise have purchased will they opt to go private (the shaded area). School level education in Britain is an example.

- **(d) State provision as a residual service.**

The fourth case is actually of the same kind, but the flat rate state service is well below the level most people would choose. In this case only those with low incomes, or who would not want much of this kind of service anyway, are left using the state service; the majority “opt out” (giving a larger shaded area of private purchase). An example of this might be social housing, not only where the physical standard of housing or its environment are poor, but also where an important part of the “quality” of the private alternative is the ability to choose location or other aspects of the property.

These are very simplified cases, but they do bring out some important points.

First, it is very important whether a private service is an *addition* or an *alternative* to what is available from the state. In the former case one might expect quite a lot of people to be combining a fairly small amount of private spending with use of the basic state service – the private sector might be broad, but not very deep. Much European health care fits into this model. In the latter case, one might expect a relatively small number of people to be spending quite a lot privately – the private sector will be deep rather than wide. British private schooling fits into this model: it is hard for children to attend state and private schools simultaneously.

This kind of difference between public services which are widely used and those which are more residualised may help explain the differences seen between (often favourable) attitudes of those using private education in the UK to state education spending and those (often unfavourable) of owner-occupiers to higher spending on local social housing.<sup>20</sup>

## **5. Conclusion: Private welfare, distribution, inclusion and choice**

In his identification of “divisions of welfare”, Titmuss highlighted both the role of the private sector as well as the state in providing welfare services, and the way in which the state can be an important source of finance for private provision. This paper outlines a framework which both systematises the distinction between public and private roles in the financing and provision of welfare and extends it to make a distinction between those areas where individuals have a choice over the level of service they receive or the provider they use.

Using this framework, the picture of the welfare mix which emerges is far more complex than a simple separation between public and private sectors, and the pattern varies between welfare services. It would be very interesting in comparative terms to see a similar analysis, putting numbers on the sizes of the different “divisions of welfare”, for other countries.

As far as the UK is concerned, over the last twenty years there have been important shifts in the roles of public and private sectors, but these have not

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<sup>20</sup>Brook et al. (1998); Emmerson et al. (1998).

been uniform either, and are not captured by a simple notion of “privatisation”. But this should not be a surprise. If one analyses the economic reasons why the state is involved in welfare activity in the first place, the strength of different arguments varies from sector to sector, and one would expect to see differences in the welfare mix.

But Titmuss was also concerned with another set of issues in his defence of universal social services. This is what we might today call “inclusion”, or what be referred to as “solidarity” in continental Europe. The National Health Service in Britain is an immensely popular institution (if underfunded by international standards). Attitude surveys consistently report that a large majority would like to see greater public spending on it, even if this meant higher taxes. It is no coincidence that spending on the NHS has been one of New Labour’s highest priorities, or that a leading Conservative politician should identify a public perception of “supposedly hostile attitudes to the welfare state and particularly to health and education” as his party’s Achilles Heel.<sup>21</sup> Even if some people add to it privately, the NHS remains a universal service.

By contrast, social housing in Britain is a residual and stigmatised service. Rationed allocations remove many aspects of choice of housing for social tenants and the housing benefit system removes any connection for most between the value of accommodation and the amount they pay for it. For the 23 per cent of households in social housing - increasingly drawn only from the lowest income groups - their experience of this part of their lives is very different from the choices and trade-offs available to the majority. While state intervention here achieves both redistribution and ensures some kind of minimum to people’s housing standards, it fails to achieve the kind of inclusion or solidarity achieved by the NHS.

This highlights a central dilemma as one looks to the ways in which the role of the state and the shape of boundaries between public and private sectors may develop in the future. With increasing affluence, one of the commodities people appear to value more intensely is that of choice. This points towards welfare systems which are more individualised - which allow individual choices

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<sup>21</sup>Lilley (1999).

out of a “menu” of options, or which allow private additions to a basic level of state provision - something which is increasingly important in UK pensions, for instance. This suggests that in future we may see even more complex “divisions of welfare” to accommodate this kind of choice.

But at the same time, particularly given the growth of market inequalities, such options and choices may deepen the other kind of division - between those receiving the basic service from the state and those opted out into the private sector, losing the inclusiveness or solidarity which the welfare state was supposed by architects like Titmuss to create. He argued in the 1950s that the different divisions of welfare were, “simultaneously enlarging and consolidating the area of social inequality. That is the paradox: the new division of equity which is arising from these separate responses to social change.” That paradox is unresolved, and if anything applies more acutely today as we try to cope with even greater social change.

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1979-80 (£ bn, 1995/6 prices)	Public finance	Public provision	All welfare activity	Public spending
Education	21.5	15.3	23.4	27.5
Health	22.7	18.3	25.5	23.6
Housing	11.7	9.9	36.9	17.2
Income Maintenance	65.9	54.7	81.9	49.4
Personal Services	3.9	3.9	4.8	4.6
Total	125.7	102.1	172.5	122.1
1995-96 (£ bn)				
Education	29.6	18.8	36.0	36.1
Health	41.0	31.7	49.8	40.7
Housing	18.5	10.0	71.1	16.1
Income Maintenance	96.4	80.0	114.9	80.8
Personal Services	10.3	6.1	13.6	8.9
Total	195.9	146.6	285.4	182.6
Total (% of GDP)				
1979-80	24.0	19.5	32.9	23.3
1995-96	27.7	20.7	40.3	25.6
Sources: Burchardt (1997), Glennerster and Hills (1998), Table 8A.1. Public spending figures exclude tax reliefs, include capital spending and in education, student maintenance grants, and use cash-flow definitions of housing subsidies.				

Table 8.1: Total Welfare Activity, 1979-80 and 1995-96

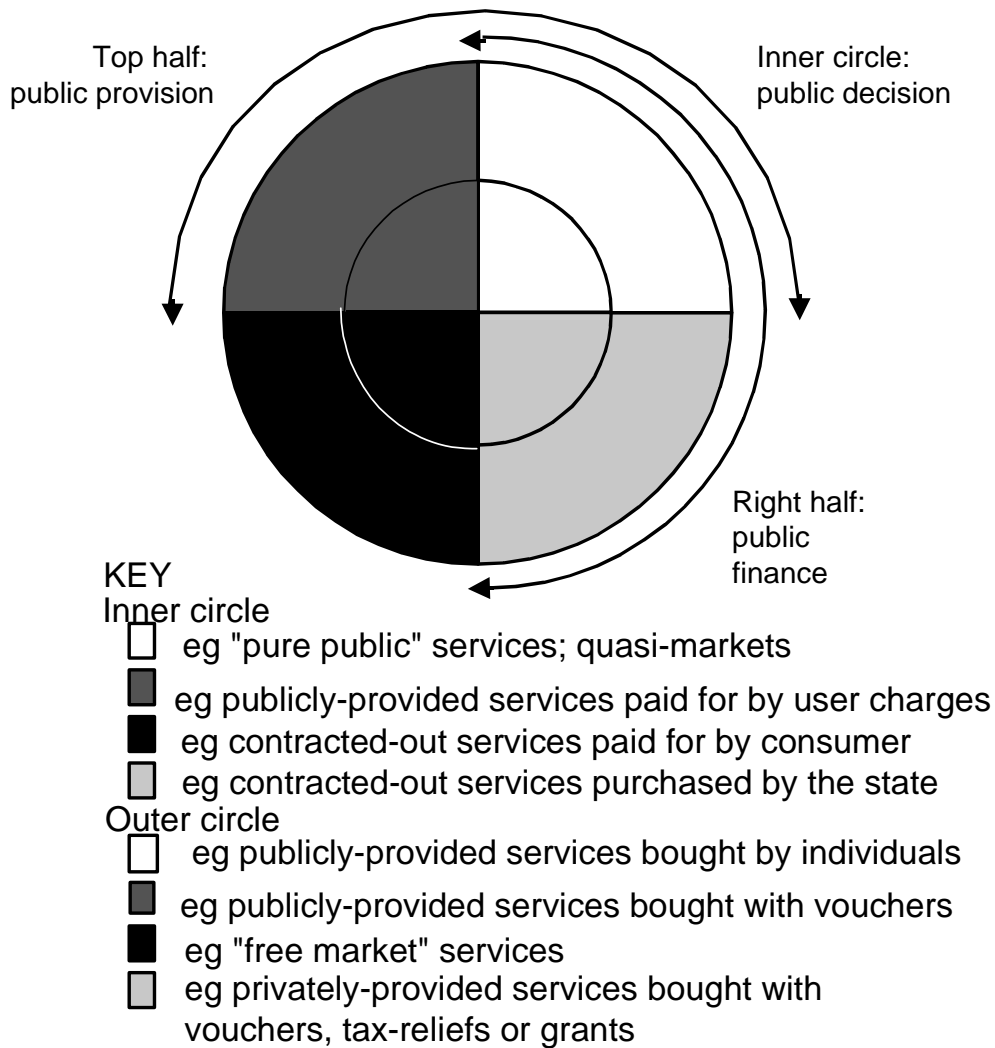


Figure 8.1: Classification of public and private welfare activity

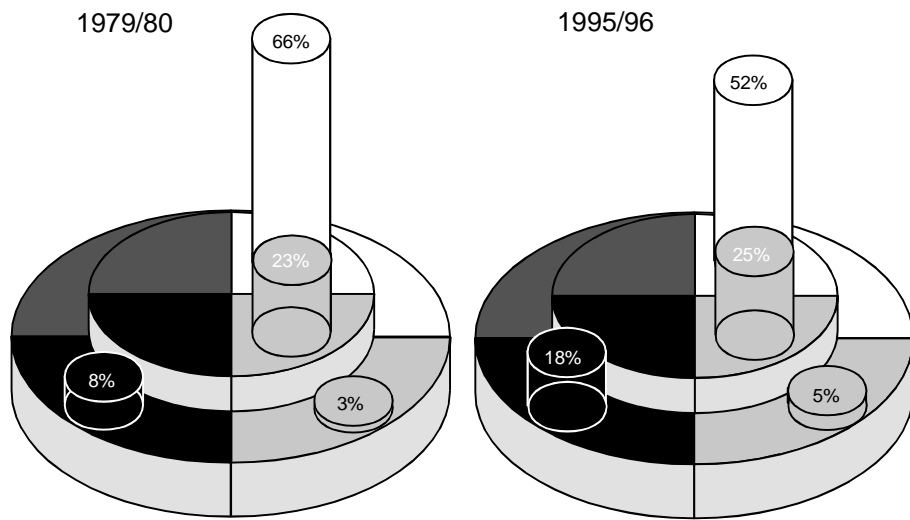


Figure 8.2: Expenditure on education

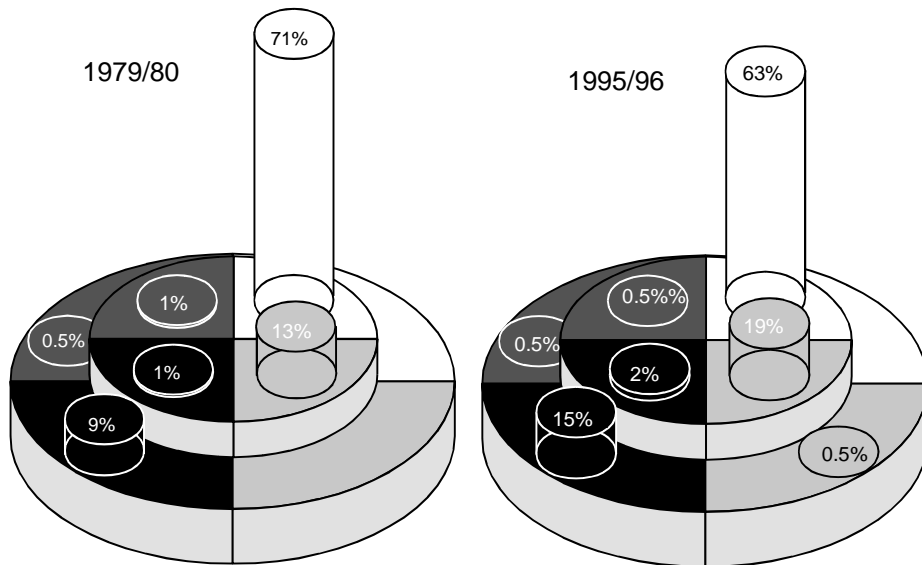


Figure 8.3: Expenditure on health

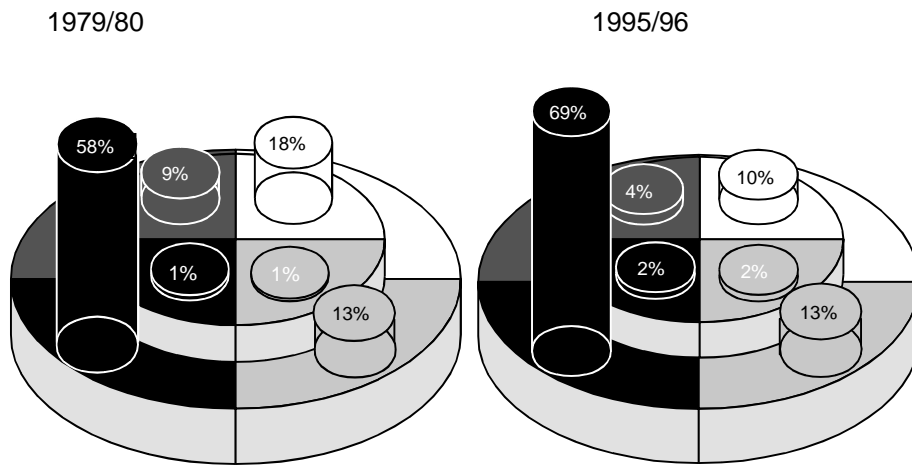


Figure 8.4: Expenditure on housing

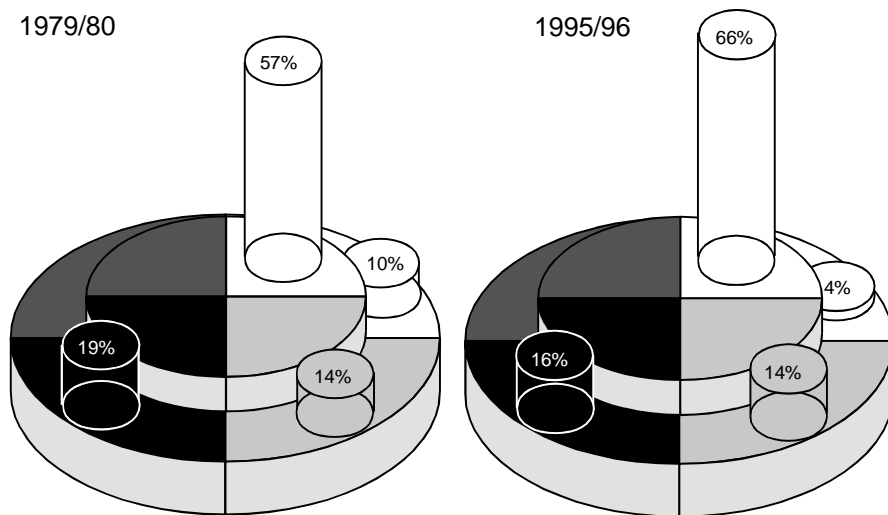


Figure 8.5: Expenditure on income maintenance

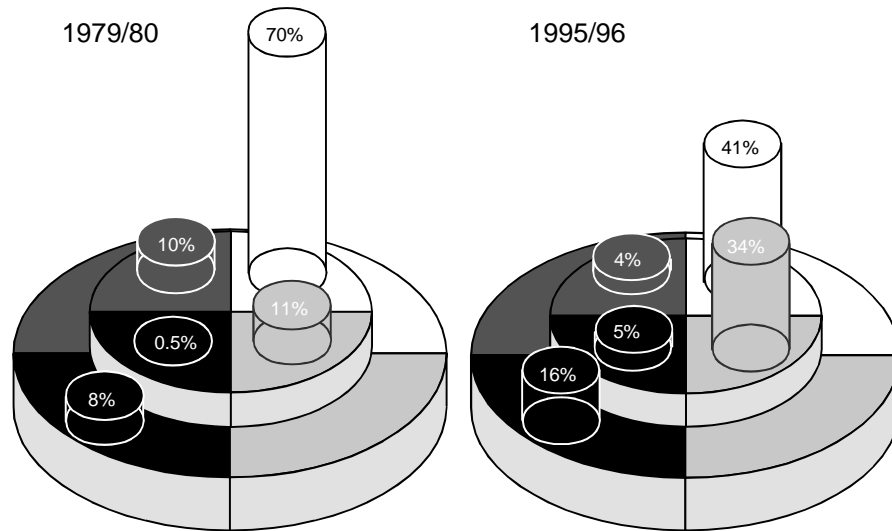


Figure 8.6: Expenditure on personal service

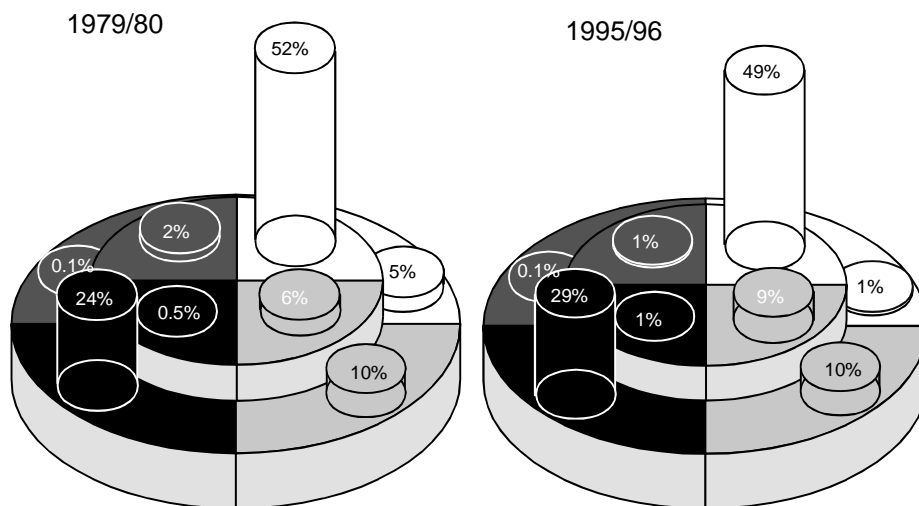
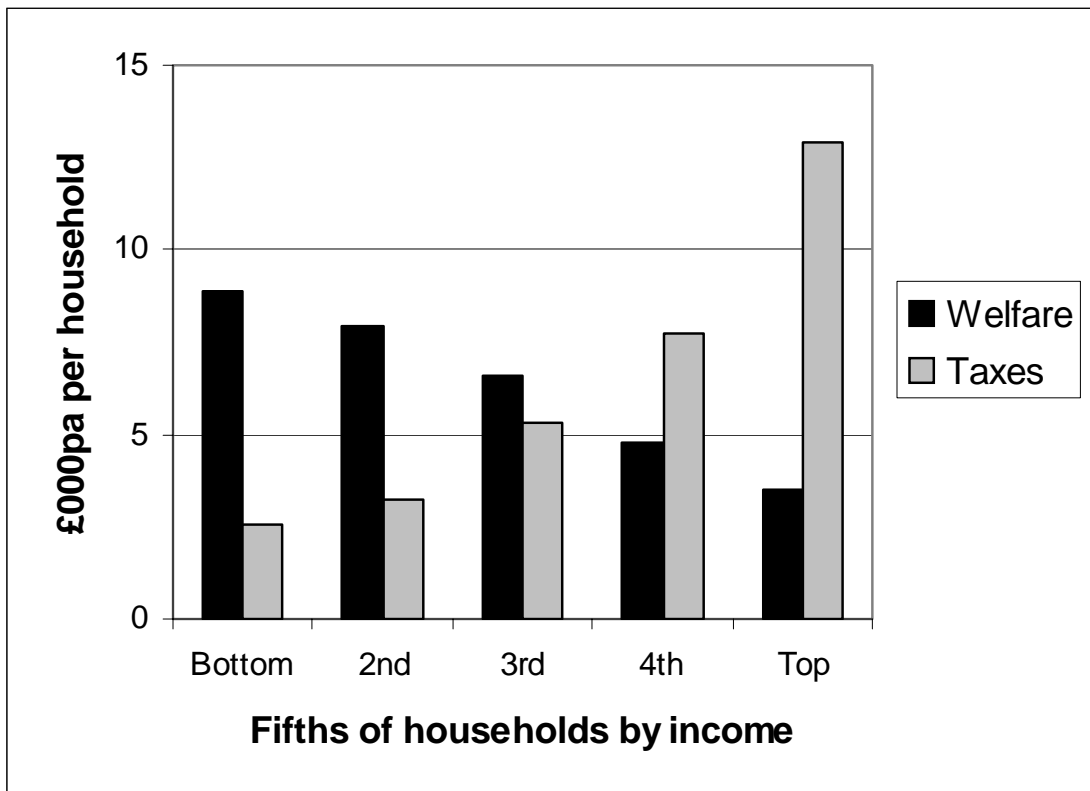


Figure 8.7: Expenditure on welfare



'Welfare' includes cash benefits and benefits in kind (health, education, housing and transport). 'Taxes' is required proportion of total tax revenue, and includes direct and indirect taxes and NI contributions.  
 Source: based on ONS (1997) p.29

Figure 8.8: Distribution of welfare benefits and taxation, 1995/6

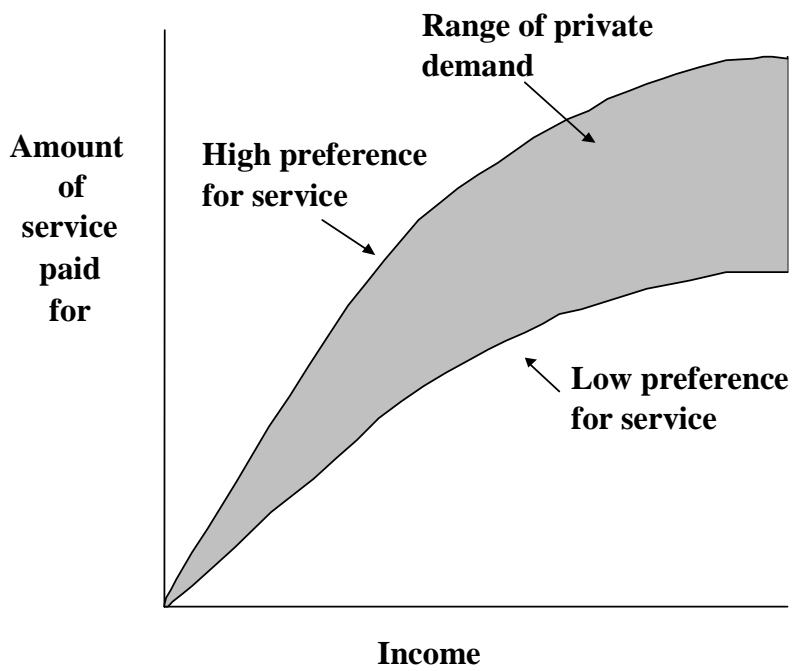


Figure 8.9 (a) No state-financed provision

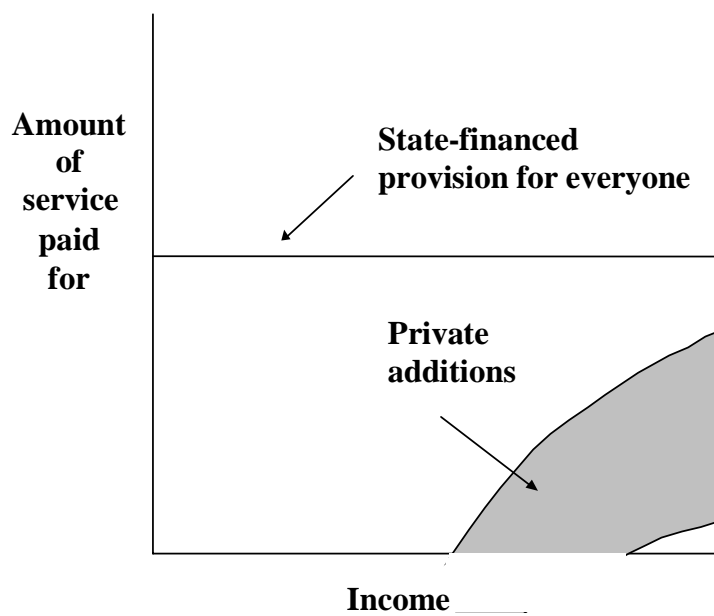


Figure 8.9 (b) Private additions to state-financed provision

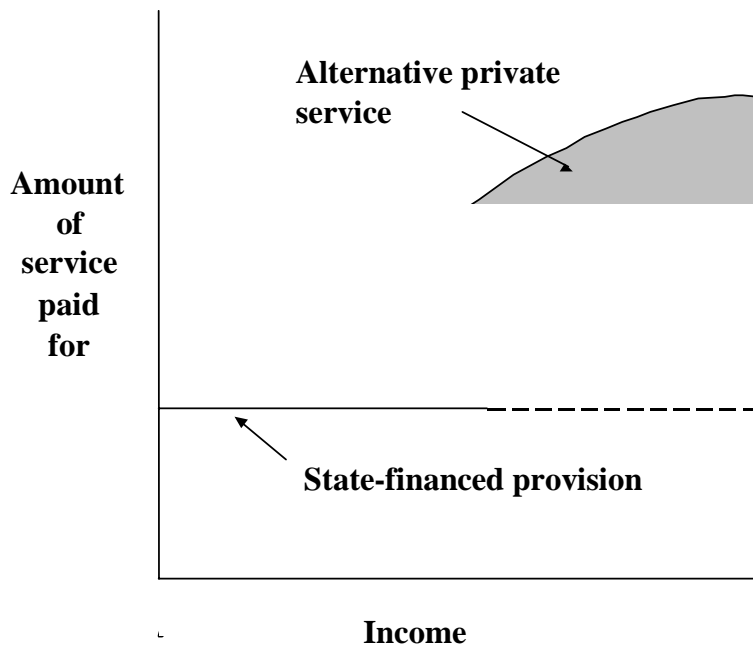


Figure 8.9 (c) Private alternatives: as a niche market

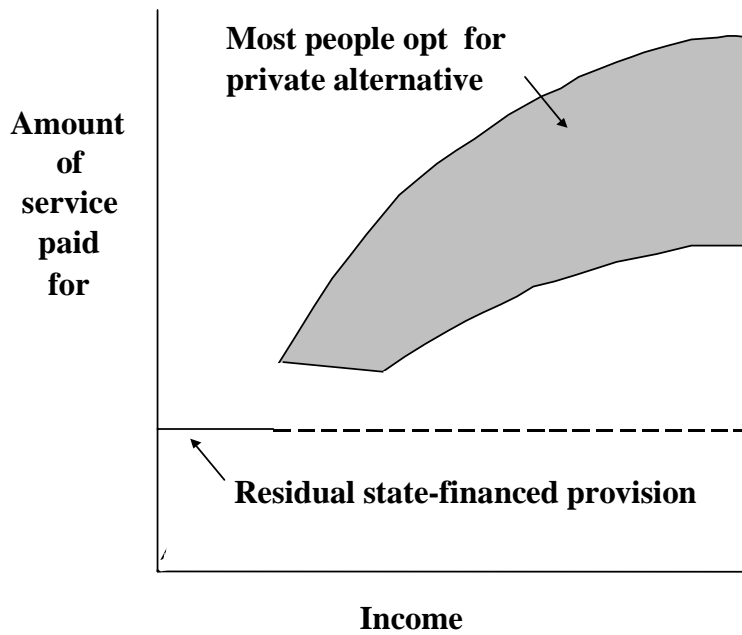


Figure 8.9 (d) Private alternatives: state-financed provision is residual