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Discriminating Customers, Responsible Patients, Empowered Users: Consumerism and the Modernisation of Health Care

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Abstract

The centrality of patient choice in the recent political rhetoric of both New Labour and the Conservative Party has prompted a renewed interest in the shift towards a more consumerist conception of health care in the UK. Accordingly, this article reports on early findings from a project in the ESRC/AHRB Cultures of Consumption Programme, exploring how the 'consumer' is constituted in narratives of health reform, and the ways in which policy documents present a particular image of the consumer as a rationale for institutional and cultural change. The article then goes on to look at the ways in which service delivery organisations have responded to New Labour's consumerist imperative. Drawing upon a series of interviews with senior health care managers in two case study locations, the article highlights ways in which choice, responsibility and empowerment have become critical points at which a consumerist orientation is articulated with established professional cultures, and how health organisations have experienced – and attempted to resolve – the tensions that result.

The image of the consumer stands at the heart of attempts to reform health systems to meet the demands of a 'modern' world in which citizens are assumed to have greater access to information and improved confidence in challenging clinician authority (Coulter and Magee, 2003; Goode *et al.*, 2004). In the UK, such a conception has been a central feature of health reforms under both Conservative and Labour administrations. The White Papers – *Working for Patients* (Department of Health, 1989a) and *Caring for People* (Department of Health, 1989b) – attempted to introduce more consumer-centred services and a measure of customer choice. The *Citizen's Charter* of 1991 (Cabinet Office, 1991) emphasised the principles of choice, ownership and responsibility, and sought to

enhance the quality of public services by providing the public with information and enhancing their rights to redress and recompense. During the 1990s the language of customers, customer care and customer service also pervaded a series of 'culture change' programmes across the public sector. Following the election of New Labour in 1997, Greener (2003) argues that there was an initial return to a more Fabian approach to health policy in the 1997 White Paper (Department of Health, 1997), but that a consumerist discourse was reasserted in *The NHS Plan* (Department of Health, 2000) and later policy documents (Department of Health, 2001a, 2002). The centrality of patient choice in the political rhetoric of both Labour and Conservative parties in 2004–5 has prompted a renewed interest in the shift towards a more consumerist conception of health care.

The consumerist model of public service provision has attracted a number of political and academic critiques (see review in Needham, 2003). Some focus on the idea that the customer cannot be a 'real' customer since he/she may not pay directly for the service, may be an unwilling or involuntary user, or may have little choice due to the absence of 'real' competition for most services (Clarke, 1997). Others take a different approach. Writing on health, Pickstone has suggested that the displacement of a productionist model of health by a more consumerist model was driven by the 1960s emphasis on choice in lifestyle, and the 1970s notion of the body as a sexual commodity for individual investment.[1] This, he argues, tends to exacerbate the inherent supply/demand mismatch in health by both increasing the level of demand and by delegitimising attempts to ration care (Pickstone, 2000). Yet others focus on the problems that consumerism might produce: for example, the increase in what Harrison and Moran term the 'consumer moral hazard' of rising demands and 'an increasingly open distributive struggle' between funders, clinicians and patients (2000: 499).

Our intention in this article is to develop the analysis in two ways. First, we examine the ways in which the consumer is constituted in narratives of reform in the UK, highlighting ways in which such narratives attempt to resolve tensions in the Labour government's overall reform programme for the NHS. Second, we explore ways in which such tensions are being negotiated in service delivery organisations as they respond to Labour's consumerist imperative. Here we highlight ways in which choice, responsibility and empowerment have become critical points at which a consumerist orientation is articulated with established professional cultures, and how health organisations experience – and attempt to resolve – the tensions that result. The data are drawn from the first stage of an ESRC/AHRB funded project entitled *Creating Citizen-Consumers: Changing Relationships and Identifications*.[2] This project compared how three different public services (primary health care, policing and social care) in two geographically and demographically contrasting areas (here designated as 'Oldtown' and 'Newtown') have responded to pressures to develop a more consumerist approach.

Constructing 'consumerism': political narratives and policy challenges

It is not our intention here to provide a summary of the policies that are intended to influence the development of a more consumerist orientation in the NHS. Rather, our aim is to highlight some of the ways in which policy documents present an image of the consumer as a rationale for institutional and cultural change. As such we are interested in policy as discourse (Ball, 1993; Fischer, 2003). Policies may be developed in a way that loosely stitches together a range of different goals and that attempts to reconcile multiple interests. However, they are presented as part of a 'story' that situates new initiatives, drives or targets into a history, and that draws on images of societal change and/or institutional problems to legitimate their proposals. Such an approach views policies – and the political speeches that surround their presentation – as providing a linguistic repertoire on which managers, professionals, user groups and other stakeholders can draw. The language of political and policy texts is therefore interesting in its own right, not because it tells us about the policy content but because it provides clues about what tensions are having to be negotiated in the construction of a credible narrative, and how successful that narrative is.

In political speeches and policy documents New Labour has repeatedly asserted the need for health services to be more strongly consumerist. Indeed, the idea of the consumer represents the 'new' or 'modern' image of health and other services in the narratives of change through which policy is explained:

Thirty years ago the one size fits all approach of the 1940s was still in the ascendant. Public services were monolithic. The public were supposed to be truly grateful for what they were about to receive. People had little say and precious little choice. Today we live in a quite different world. We live in a consumer age. People demand services tailor made to their individual needs. Ours is the informed and inquiring society. People expect choice and demand quality. (Milburn, 2002a)

This simple narrative of change masks a number of difficulties that Labour is having to negotiate in its modernisation programme for the NHS (Clarke, 2004). The government is attempting to reconcile the social democratic conception of a free, universal health service with a range of modernising strategies that draw on private sector investment and resources. It is seeking to secure middle-class 'buy in' by ensuring a more personalised, consumer-friendly and choice-oriented service. Finally, it is struggling to negotiate different conceptions of equality.

The tensions between these different strategies can be traced in the evolution of Labour's attempt to modernise health around new forms of relationship between health services and the publics they serve. *The NHS Plan* set out the problem that New Labour is seeking to address:

The NHS is too much the product of the era in which it was born. In its buildings, its ways of working, its very culture, the NHS bears too many of the hallmarks of the 1940s. The rest of

society has moved on. On July 5th 1948, the day the NHS was founded, the high street banks were open between 10am and 3pm. Today, the public has 24 hour access to banking services . . . In 1948, deference and hierarchy defined the relationships between citizens and services. In an era of mass production needs were regarded as identical and preferences were ignored. Today, successful services thrive on their ability to respond to the individual needs of their customers. (Department of Health, 2000: 2.9–2.12)

Here, New Labour's attempt to redefine the relationship between health services and the people who use them drew upon a simplified version of history – one involving the disappearance of several post-1940s decades – to frame two related and familiar New Labour themes, albeit ones with echoes of Thatcherism. The first is the need to move on from the days when *needs were regarded as identical* to a situation where services are tailor-made in order to be responsive to the *individual* needs of their customers. This is an individuating conception of diversity: different needs are individually, not socially distributed. Diversity requires responsive services, which in turn links to the second theme: that of the distinction between producers and consumers as having different interests. Responsive services are here conceived as those which are geared to the *interests of users* rather than the *convenience of producers.*

We want to draw out two sets of issues in this consumerist set of representations: the conception of 'modernity' on which they draw (and the implications for user/producer relationships); and the ways in which questions of needs, resources and inequalities are reconciled (or not) with the consumerist imagery.

Constructing modernity

The sociological analyses of Giddens (1990), Bauman (1992), Lyon (1999) and others associate consumerism with the development of reflexive modernity or post-modernism. Modernity in policy texts and political speeches is a rather more mundane, but highly normative, concept. It conveys an image of an already transformed society that requires significant reform – or modernisation – of the welfare state. The health texts are underpinned by the assumption that the individuation thesis of Giddens and others has been realised, and that the collective identifications and solidarities of the past have already been displaced by a more consumerist, individual set of orientations.

We live in a consumer age. Services have to be tailor-made not mass-produced, geared to the needs of users not the convenience of producers. The NHS has been too slow to change its ways of working to meet modern patient expectations for fast, convenient, 24 hour, personalised care. (Department of Health, 2000: 2.12)

Such images of 'the modern patient' are deployed in order to legitimate the need for change in the interests of a public that has *already been transformed* into 'discriminating consumers'. Individuation, consumerism and other symbols of

modernity are presented as taken-for-granted facts that shape expectations of health care.

However, rather than simply *reflecting* a pre-existing and taken-for-granted reality, New Labour's consumerist discourse can be viewed as *constituting* new forms of relationships and patterns of identification. We want to highlight two key features of this process of constitution. One is the construction of new relationships between health users and providers. The modern health service user is conceptualised both as 'empowered' and as 'responsible':

The era of the patient as the passive recipient of care is changing and being replaced by a new emphasis on the relationship between the NHS and the people whom it services – one in which health professionals and patients are genuine partners seeking together the best solutions to each patient's problem, one in which patients are empowered with information and contribute ideas to help in their treatment and care. (Department of Health, 2001b: 9)

These images of partnership imply a fundamental shift in the role and status of the health practitioner, one in which their knowledge and power lose some of their authoritative status. Such a shift can be viewed as part of – and indeed helps legitimate – wider shifts including the emphasis on 'what works', the establishment of NHS Direct, shifts in the role of nursing and allied professions that help demystify the 'special' status of the medical practitioner, the emphasis on interdisciplinary work, and the shift in emphasis towards health promotion and prevention. This aspect of consumerism – in which the empowered user is constituted as knowledgeable and able to participate in treatment processes as well as to be responsible for their own good health – is therefore at the centre of, and necessary to, a much wider programme of modernisation and reform. Such images of empowerment tend, however, to draw on a zero-sum conception of power that has been widely criticised (see Cruikshank, 1999).

The second feature of consumerism as constitutive of new relationships is linked to the discourse of 'choice' and the narrative of change into which it is inserted:

For fifty years, the structure of the NHS meant that governments – both Labour and Conservative – defended the interests of the NHS as a producer of services when they should have been focussed on the interests of patients as the consumers of services. In today's world that will no longer do. People today expect services to respond to their needs. They want services they can trust and which offer faster, higher quality care. Increasingly they want to make informed choices about how to be treated, where to be treated and by whom. (Milburn, 2002b)

The assumption underpinning the image of the patient as 'discriminating customer' is that people have become used to flexible, responsive, user-centred services delivered in the market place and want the same when they come to the NHS. It is possible to identify a few difficulties inherent in such an assumption. The first relates to whether or not consumers do actually get what they want from

the commercial sector – much of which is increasingly based on the decidedly unfriendly relations of the call centre. The second concerns whether people really do expect or want the NHS to behave like a company or whether it has a rather different place in the popular imagination. But the third, rather more serious, difficulty centres on the role and status of 'choice' in the reform programme and the tensions between this and other political discourses – notably those of 'equality' and 'need' – that remain significant in Labour's political lexicon. It is this third difficulty which we wish to explore in some detail and to which the next section now turns.

Wants, needs and equalities

The place of choice at the heart of consumerism has implications for equality that are politically troubling for New Labour. However circumscribed, the operation of choice in health opens up the possibility of growing inequalities between 'good' hospitals and health trusts (those in which middle-class patients opt for treatment) and a residualised, second-class set of facilities. Equity remains, however, a key issue for New Labour. Political speeches and policy documents offer several different resolutions to this tension. Early policy texts repeatedly emphasise the importance of geographical consistency to overcome spatial inequalities (the so-called 'postcode lottery'). Later the emphasis shifts to the idea that the exercise of choice by some will raise quality for all:

Those who defend the status quo on public services defend a model that is one of entrenched inequality. I repeat: the system we inherited was inequitable. It was a two-tier system. Our supposedly uniform public services were deeply unequal as league and performance tables in the NHS and schools have graphically exposed. . . . The affluent and well educated meanwhile had the choice to buy their way out of failing or inadequate provision – a situation the Tories 'opting out' reforms of the 1980s encouraged. It was a choice for the few, not for the many. (Blair, 2003)

Extending choice – for the many, not the few – is a key aspect of opening up the system in the way we need. But choice for the many because it boosts equity. It does so for three reasons. First, universal choice gives poorer people the same choices available only to the middle-classes. It addresses the current inequity where the better off can switch from poor providers. But we also need pro-active choice (for example, patient care advisers in the NHS) who can explain the range of options available to each patient. Second, choice sustains social solidarity by keeping better off patients and parents within the NHS and public services . . . Third, choice puts pressure on low quality providers that poorer people currently rely on. It is choice with equity we are advancing. Choice and consumer power as the route to greater social justice not social division. (Blair, 2003)

It is often said that choice and equity are in some way in opposition. I don't accept that argument. Consumers act individually but the effect of their actions is communal. The cumulative effect of individual choices increases choice for others. In this sense choice widely available is not inimical to equity, it is a driver for change for everyone. So often in state provision of services universal provision meant the equity of the mediocre. That might have been acceptable to those lying down patients of the past but it will not do for the standing up consumers of the future. What we aspire to is the equity of excellence and choice is a necessary, though not sufficient,

part of that transformation. (Cayton, Director for Patients and the Public at the Department of Health, 2003)

Here we can trace a number of different themes in Labour's reform programme, but we want to focus on how equality is linked to the idea of the (defective) public services of the post-war welfare state: one based on scarcity, rationing and a strongly paternalistic approach. The idea of universalism, on which the welfare state was built, is now associated with 'the equity of the mediocre'. This redefinition of equality – uncoupling it from its association with universalism and re-coupling it with the discourse of consumerism and choice – is a strong theme in both policy and political discourse.

Challenging professional power

However, the texts do not tell a simple story of a shift from collective to individual identifications, or from needs to demands or choice. Historical commitments are aligned with 'modern' constructions in an apparently seamless way:

We need an NHS true to the principle of care on the basis of need, not ability to pay, but personalised, built around the individual patient. Both require an end to the 'one size fits all' mass production public service. The purpose of the 20th century welfare state was to treat citizens as equals. The purpose of our 21st century reforms must be to treat them as individuals as well. (Blair, 2002)

These extracts suggest how political discourse is constructing – and legitimising – the development of a more consumerist relationship between the NHS and the public, a public reconceptualised to fit the image of a 'modern' society. They carry an implicit – and sometimes explicit – set of challenges to professional, occupational and organisational power. First, they potentially undermine the hegemony of the medical model of health. The patient is no longer an assemblage of symptoms to be diagnosed and treated, but a person – in some texts a 'whole' person – requiring a *personalised* response (National Consumer Council, 2004). This conception is one that is aligned with developments within the health care professions themselves, notably the now widely accepted idea that the involvement of the patient in their own treatment and care is likely to produce improved health outcomes. Second, the image of modernity promulgated in the texts is one that challenges the supremacy of professional judgement of clinical 'need' by superimposing a discourse of 'preference' and 'choice'. This challenge is not new: clinical autonomy has been constrained in a number of ways over the last decade or so through the use of market mechanisms, the rise of managerialism, the development of targets and performance measures, quality programmes and other measures. But here for the first time the service user comes to embody the challenge. The assumption that patients are likely to be more informed, more empowered, more articulate, more demanding opens up the possibility of

some loosening of what we have termed the 'knowledge-power knot' on which professional power is based (Clarke, 2004). Across both of these challenges to professional power the government is constructed as 'on the side of' the patient in the face of the intractability of professional power and producer dominance.

Consumerism, then, is not a single phenomenon but elides a number of different developments. Some are concerned with legitimating the reform and restructuring of the welfare state (in the name of a 'modern' service for a 'modern' people). Here a narrative is constructed that collapses history and that reconstructs the post-war welfare state as producing, rather than ameliorating, inequalities. Some appropriate professional concerns about how best to secure better health outcomes through a partnership-based and person-centred model of care. Some promulgate consumerism as a driver for change. Here government looks 'over the heads' of professionals and managers to the health user as a means of opening up the health service to new ways of working. Some are concerned with installing new commissioning processes and funding regimes organised around the idea of patient choice. The interaction between these different developments produces tensions that are then devolved to service delivery organisations to resolve.

In the next sections we explore ways in which consumerism is understood by senior health service managers, and how they experience – and negotiate – the tensions that are produced as they respond to the consumerist imperative.[3]

Institutional adaptations

This section uses the term 'institutional adaptation' rather than 'policy implementation' to signify our interest in how organisations interpret, enact and negotiate the tensions arising from new policy agendas. Consumerism is not imposed on or inserted into a static health care system, but is articulated with existing trajectories of change in uneven ways. The differences between 'Newtown' and 'Oldtown' in our study illustrate the point. In Newtown the younger age profile of the population meant that we were told several stories about the difficulties of responding to a more informed public, skilled at using the internet and other sources of information. The primary categories into which the public as service users were grouped were 'articulate' and 'deprived', with concerns about the impact of the choice agenda on the latter. There was an established tradition of health professionals working in partnership with other agencies to address health needs and there was a strong health promotion agenda. In Oldtown there was more emphasis on generational differences:

Respondent: We've got quite a mixed population really but there's a lot of older people in [the town] . . . who've been brought up thinking that the NHS was the best thing since sliced bread and that it's wonderful, there are people that look after them and it's free, wow, don't question it.

Interviewer: So how do you think issues like choice and consumerism apply here?
Respondent: It slightly goes against the whole culture of the NHS being free and in society and not excluding people because consumerism can be – it's a contentious thing isn't it because if people are able to choose then what they must understand is they might be taking choices away from other people, so it kind of goes against the whole citizenship and social stuff. (Oldtown 2)

The 'whole citizenship and social stuff' mentioned here stands as the antithesis of consumerism. The trajectories of change in Oldtown were geared towards the shift of emphasis to primary care and the establishment (through public–private partnership) of four new multi-disciplinary health centres that were about 'redefining' health care to meet the complex *needs* of those living in an area of high deprivation, and to attract GPs in response to severe shortages. This is a very different narrative of change from those highlighted in the first section: community needs, rather than consumer demands, are viewed as the driving force and staff are acknowledged as a critical resource. What is notable in the interviews as a whole is that the language of government documents is rarely replicated. Although government policy was being pursued, its aims were being interpreted through a more professionalised vocabulary of user empowerment or the concept of a new partnership between patient and doctor.

Reconceptualising the service user

Rather than seeing the consumer as the all-powerful driver of a more accountable, responsive and user-oriented service, the interviews offer a number of different conceptions of the service user. Indeed, they suggest ongoing struggles to reconceptualise the user in ways that draw on developments in professional conceptions of best practice, that respond to some of the challenges of user movements, and that acknowledge the need for legitimacy in the eyes of patients and community.

In the interviews we can trace a *professionalised* re-conception of the patient, not as a discriminating consumer but as someone whose health needs will be better met if services are re-designed around a number of principles. One suggests a holistic conception of patient needs:

There is no point in having super duper health centre if they are not on a bus route . . . [or] if the people are too frightened to come in because of crime . . . We have to deliver services in a way that working people can access without having to have time off work and things. (Oldtown 1)

However, the conception of the relationship between provider and service user still tended to be dominated by clinical models of care, albeit models in which patient experience was accorded a higher value because of its impact on health outcomes. In Oldtown an initiative was underway to research patient experience of their treatment – the 'patient journey' – in order to compare this with best practice in terms of specific health problems. The idea of the patient journey

offers a more person-centred concept of the service user, but this is still a long way from the image of the active, informed or empowered patient: it is a source of (aggregated and codified) data that can inform service planning in order to secure better treatment and health outcomes.

The idea of the '*expert patient*' signified rather different changes in the relationships between provider and service user:

The idea is that these patients who are going to be sent on the expert patient programme are the patients that present, sort of every week, that they do have . . . a chronic illness, but they just seem to need reassurance about all other aspects of their health and so will present week after week. So there is a place now where they can learn how to be more independent. And that is a government initiative. (Newtown 3)

The language of 'expert patient' was sometimes rejected in favour of a more professionalised concept of 'guided patient self-management' (Oldtown 4: a senior clinician with a GP background). The aim was to secure better health outcomes, but the change of language explicitly rejected the linking of 'patient' and 'expertise': the challenge to professional power was thus minimised. Other shifts in language suggest ways in which policy discourse is being appropriated and reworked. In Newtown one respondent linked patient expertise not to individual disease management but to a more collective sharing of knowledge and experience among patients. She spoke of how parents of children who had been cared for in the hospital's special baby unit, but who had recovered and returned home, came in and talked to parents of children currently in care; and of how adults who had been in intensive care came in to explain to current patients what they could expect when they got home.

And that's kind of my original definition of expert patient but it can happen in all sorts of fields, for example diabetes. And now the Expert Patient programme that the government is supporting [has come in] and it's a training course . . . it teaches them self-help skills, how to deal – different ways to deal with pain, different ways to deal with depression caused by pain, and so forth, improves their confidence, improves their ability to speak to health care professionals, all of which I think is terribly important, a jolly useful thing to happen. But I think calling it the Expert Patient programme was really unhelpful. (Newtown 3)

Here we have used capitals to signify 'official' policy usage of the term and lower case to signify the everyday usage among those we interviewed. This occurs later in our discussion of Choice and choice. The distinction between official and everyday usage suggests ways in which government and professional discourses are aligned in complex articulations, and how such articulations reflect particular points of institutional adaptation.

One point of correspondence between policy texts and professional discourse is the idea of patient empowerment through access to information:

Going to the doctor and just standing there like a stuffed dummy and expecting him to tell you what is wrong with you is, I think, almost a thing of the past. You've got to be proactive

whenever you go and see a health professional and there's no better way of being proactive than learning about it before you go. Therefore you have got to have patient involvement and public involvement. . . . It enables you to be more self aware about your own body, about your own condition, and to try to get the best from the system you possibly can. (Newtown 1)

This can mean anything from equipping patients with information to 'empowering' people by giving them more choice. Empowerment also encompasses more collective conceptions of participation in which service users are consulted and involved in deliberations about service planning. In both Newtown and Oldtown such developments were viewed with considerable pride:

I do think we are moving away from this but it has been a tendency in the past, it was always kind of 'we'll decide what we're going to do and then we'll tell you' so very much trying to turn that round . . . you know, asking people what they want from a service instead of trying to decide on their behalf . . . real involvement is actually in the decision-making stuff. (Newtown 3)

The building of the new centres has been done with patient consultation, and the movement of the services has been done with public involvement . . . we have to check that they don't dip in quality and also that the patients are happy to receive services in a different sense, not just because we think it is a good idea. If the patients aren't coming, or they think it is not a good service, then it is not a good idea. (Oldtown 1)

The boundary between conceptions of the *empowered service user* (linked to knowledge) and *discriminating customer* (linked to choice) is slippery:

If you talk to people about choice, how a lot of people will think is that it is about choosing whether you go to this hospital or that hospital. But from my point of view it is around choice right down to the patient level, and it is a bit greater than what hospital you go to, it's around how do you want the service delivered to you . . . There are these options available for treatment; which one fits you best?(Oldtown 1)

Here we can see the government discourse of Choice – denoting access to alternative providers where patients have been on a waiting list for a particular time – being reworked to signify a more professionally recognised concept of choice, defined as involving patients in treatment decisions.

The concept of choice, then, provides a bridge between professional and consumerist discourse. It is welcomed where it can extend or amplify a pre-existing professional ethic, especially ones associated with the empowerment of particular groups such as people with learning disabilities or mental health service users. However, this is rather different from Choice as elaborated in government policy. In professional discourse, choice means involving patients in decisions about appropriate treatments in the interests of more effective health outcomes (rather than giving a choice of provider). Any more expansive conception, linked to patients expressing wants or demanding particular treatments, was viewed as a source of difficulty, since it raises the problem of how clinical definitions of 'needs' might be aligned with the 'wants', 'preferences' or 'choices' of the service user. One respondent told of how a storyline on *Coronation Street* about a woman

who had not had smear tests dying from cervical cancer had led to a distortion of clinical priorities, with patient demands displacing the health service's focus on 'need'. In another interview 'giving patients what they want' was equated with the approach of some GPs in the past who (reputedly) gave repeat prescriptions on patient demand. The attempt to change this practice had met with strong patient resistance.

'Needs' and 'wants', then, are contested concepts, and form a point of conflict between clinician and patient. The tension between them was a frequent theme in the interviews. Rather than letting more articulate patients determine spending patterns, one respondent (who had a nursing background) argued that:

The money would be better spent targeting those people who don't ask but have the greatest need. And they would be the people who are smoking, who have lots of chronic diseases such as diabetes, heart disease, COPD.[4] (Newtown 3)

Here we can see governmental emphasis on chronic disease being reconciled with a professional discourse on health needs.

In this section we have described a number of processes of 'discursive articulation' in which consumerist discourse is reworked through professional vocabularies of meaning. In the process some meanings are amplified – for example, the idea of patient involvement and empowerment – while others are marginalised. The idea of the patient as discriminating customer seldom appears, and when it does it is immediately reworked in the form of a duality of 'needs' and 'wants'. This is not a case of professional refusal or resistance to the government imperative, but can be understood as a more positive attempt to appropriate elements of consumerist discourse in order to secure the professional goals of improved health outcomes. Such outcomes were to be supported through enabling patients to make informed treatment choices, enhancing their expertise and finding ways to make them more 'responsible' for their own health. All of these ideas can be traced in the political and policy documents we analysed, some of which we refer to earlier. However, their meaning is subtly detached from the political narrative of change supporting the modernisation of the NHS and reworked into a more professional narrative of progress towards better models of clinical practice based on a partnership model of health care.

Negotiating the dilemmas: 'choice' and 'equity'

The interviews suggested that senior mangers and clinicians had a sophisticated understanding of the concept of choice and were well able to deconstruct it:

It depends, in health – what you mean actually by choice, whether there is choice to be had in that particular area and actually who that choice is ultimately going to benefit. (Newtown 3)

Nevertheless, they were having to engage with the Government's Choice agenda – at the time based on the requirement that health authorities offered patients an

alternative provider where they had been on a waiting list for six months or longer. In Oldtown the authority was establishing a number of 'Choice Centres', essentially call centres through which patients could be offered an alternative provider where the hospital to which they were originally referred found that it could not meet the [then] six month waiting list target. In contrast to the professional discourses of choice described in the previous section, Choice is coupled to a more managerial agenda of processing patients, redesigning systems and meeting government targets in the most efficient way possible:

The reality when it is fully up and running, everything operating, you know, patients going through, the idea is that it will be like a production line, working seven days a week, fourteen hours a day, you know, so working flat out. (Oldtown 3)

The interviewee spoke about the challenges of finding the right 'basket of procedures' on which such choice could be offered, and of staffing the new centres by drawing heavily on overseas teams. However, the opportunity to seek an alternative provider was limited to certain categories of patient: those with high blood pressure or who were overweight, and therefore a higher risk in clinical terms, were less likely to be offered this form of choice.

Although managers and senior clinicians were forging ahead on implementing the Choice agenda, they remained deeply concerned about equity and were pursuing it in at least two different forms. One was what one respondent termed a 'global' strategy, focusing on improving health inequalities through programmes to persuade people to stop smoking or eat more healthily. A second was to target resources to particular groups: travellers, asylum seekers, young people with drug or alcohol habits and so on. Consumerism was viewed as undermining both:

The old adage is that we shouldn't be going down to a medium level, we should be trying to raise everything to a higher level. So as soon as you start taking resources away from somewhere else, they are going to start shouting, the self-empowered consumer in that area is going to start complaining. (Oldtown 3)

The smoothing over of the tension between choice and equity in the policy documents cited in the first section, in which choice is viewed as driving up standards for all, is clearly not convincing those who have to deal with the reality of resource decisions on the ground. The tensions stubbornly refuse to go away. But, although the source of these tensions lies in the general programme of modernisation, they are experienced as problems for the *specific* authority, the *particular* practitioner, the *individual* budget holder or commissioning manager. As such, we can see how consumerism serves to individuate the tensions between needs or demands on the one hand and resources on the other. Despite oscillations and inconsistencies as consumerism is overlaid on different trajectories of change, and interpreted through different professional discourses, the move towards

a more consumerist, choice-based conception of health serves to mask the continued need for rationing and priority-setting at the local level.

In political speeches and policy documents the tensions between equity, need and choice are reconciled into a seamless narrative of the move towards modernity. The more material questions about resources, rationing and priority setting are passed on to the 'empowered' clinicians and managers responsible for delivering services. This is well recognised by many of our respondents:

Respondent: Throughout, they [government] have got to realise the consequences, and I've touched on quite a few of them, but when the government sets in train a policy I think they have got to think it through and then they have got to acknowledge that even though they've tried to think about it as much as they can, there are going to be consequences they haven't thought of. That is the purpose of piloting things, but what happens is that they might pilot it, they might not, and even if they do they usually don't wait for the pilot to finish or report before they actually get everyone else to do it.
Interviewer: What do you think those consequences would be, if any?
Respondent: Choice combined with payment by results could easily lead to bankrupt hospitals, it could also lead to hospitals saying we're not going to carry out that particular treatment because it costs too much. It could lead to patients travelling up and down the country . . . then any sort of green policy goes out of the window, doesn't it? (Oldtown 3)

One might conclude that consumerism is a site of resistance and struggle. However, simple formulations of resistance would not be justified because of the many subtle ways in which our respondents were attempting to install more user-centred and customer-responsive services. They were doing so in a way that attempted to reconcile two very different imperatives. One was to meet government targets and to reconfigure services in line with policy imperatives (as in the establishment of 'choice centres' in Oldtown). This was a matter of redesigning systems and procedures. The second was to pursue developments to secure professionally defined goals. The excitement expressed by some respondents to the idea of the 'expert' patient or the 'responsible' health user can be viewed as an attempt to secure more effective treatment alongside moves towards better demand management. The interviews suggest how many of the professional developments taking place in health – more emphasis on health promotion, more person-centred care, more effort to inform and involve the patient in their treatment – were being elided with the idea of a more consumerist approach. In the process the consumer was being decoupled from the market-oriented government discourse of choice and reworked into a more professional narrative of improved treatment outcomes.

Conclusion

Consumerism suggests a fundamental shift in the relationships between health providers and users, one in which the 'knowledge-power knot' of professional

authority is partly unravelled and 'producer power' challenged. The Labour government has sought to call into being modernised conceptions of the service user. No longer the universal 'patient', we can trace in successive policy documents a shift to conceptions of the discriminating consumer, expert patient, responsible health user, demanding consumer and so on. These conceptions – and the narratives of change in which they are located – serve to shift the balance of power not only between health users and providers but also between government and health practitioner, with government standing as the symbolic champion of consumer power in the face of what are presented as entrenched 'producer interests'.

However, the disjuncture between professional and governmental interests should not be over-emphasised. The interaction between consumerism and professional practice is messy, uneven and contested. Consumerism itself provides a new linguistic repertoire and a new set of institutional logics of appropriateness on which both professionals and service users may draw. It may be used to legitimate claims on the part of groups of professionals with a commitment to user-centred services (examples in our study included those with backgrounds in user advocacy or learning disability services). It may be used by senior managers to challenge forms of professional power (as in the attempt to redesign services around locality-based multidisciplinary teams in Oldtown). It may be used by service users – and user groups – to make new claims or articulate new demands.

This means that we have to unpack consumerism itself rather than viewing it as a coherent entity or logic that should be either welcomed or resisted depending on one's political persuasion or professional view. Shaw and Aldridge (2003) group definitions of consumerism into three categories, tracing the significance in the literature of consumerism as a social movement; as a way of life that involves a transformation of the self; and as an ideology that legitimates capitalist society. In this article we have traced ways in which consumerism can also be understood in terms of both political and professional *discourse*. We have suggested ways in which consumerism takes the form of an *organising logic* that has the potential to influence hierarchies of knowledge and power. We might go on to suggest that consumerism is likely to form an increasingly important *regime of surveillance* as targets about responsiveness and choice become more centrally embedded in processes of audit and inspection. In the later stages of our project we have traced how consumerism forms a *point of identification* that may be in tension with other identifications among both users and providers. But in each case we have to understand how consumerism as discourse attempts to link a number of different ideas – about history, about modernity, about equality, about public services – into an uneven, uncomfortable and often contradictory alignment.

Notes

1 The idea that the productionist model of health has been displaced by a more consumerist model is disputed by Harrison (2002).
2 Part of the *Cultures of Consumption* Programme.
3 Data were generated via ten in-depth, semi-structured interviews with senior/strategic health service personnel in Newtown and Oldtown. Interviewees were chosen with the input of the Chief Executive of the PCTs in each town, following an initial meeting which allowed us to explain the objectives of our research. Additional subjects were identified during the course of the interviews. The interviews were taped and the transcripts analysed using an N6 coding framework.
4 Chronic Obstructive Pulmonary Disease.

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