5

Managing Consumerism: from Policy to Practice

The consumerist policies we traced in Chapter 3 produced a new set of dynamics within public services. Rather than viewing this in terms of the conventional separation between policy and implementation, this chapter draws on extensive interviews with senior managers in health, policing and social care to trace the processes of institutional inflection and translation that were taking place at the time of our research. The interviews explored how managers saw pressures towards consumerism in their service and how these processes intersected with other changes, pressures and demands. In this chapter:

- we consider how they approached the process of adapting their organisation to consumerism;
- we explore the implications of such changes for staff and people who used the services;
- we assess the possibilities and problems that such developments created for the services.

The institutional shifts in public services over the last three decades have placed such service managers in a distinctive position. The processes of decentralisation and devolution have given managers increasing 'freedom to manage', albeit in very particular and constrained ways (see, *inter alia*, Clarke and Newman, 1997; Kirkpatrick et al., 2004; Pollitt et al., 1998). One element of this managerial relative autonomy is the task of negotiating the organisation's intersections with different sorts of 'stakeholders'. In terms of the institutional diamond framework that we introduced in Chapter 3, managers represent the 'organisational' corner. Managers identify the organisation's needs and interest and speak for its mission, values, purpose and direction. They negotiate, juggle and try to reconcile the different pressures from other stakeholders visible in that diamond: government (in its many facets); the staff of the organisation (multiple occupational groups); and the public (a complexly differentiated field; including roles as users, taxpayers, voters, citizens and even employees of public services).

Public services are settings where active translation, transformation and enactment take place. Each of the three services we studied is marked

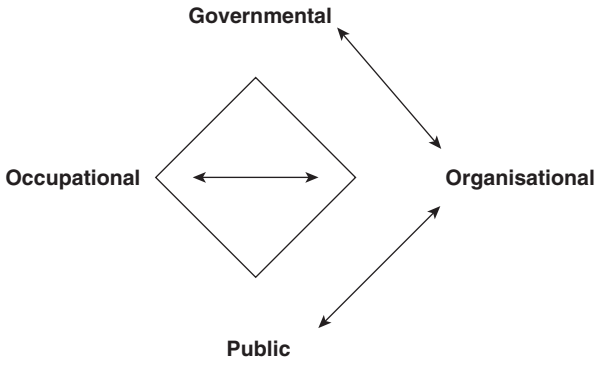

Figure 5.1 *The dynamics of institutional adaptation*

by distinctive *institutional formations*, and by distinctive *institutional trajectories*. By institutional formations, we mean the composite of organisational and occupational cultures, dominant (and other) patterns of relationships within organisations, between organisations and between services and the public. In the process of turning policy into organisational practice, managers occupy this distinctive position of trying to make policy fit the organisation, and the organisation fit the policy. This does not mean that managers form a neutral conduit through which policy passes into practice. On the contrary, the process of 'implementation' is an active one in which policy is translated into the institutional environment (see Newman, 2005b). Nor are managers disinterested observers or witnesses whose views can provide a transparent reflection of these processes. Managers are also 'stakeholders', trying to establish organisational directions, purposes and values in the face of competing conceptions of what the organisation might be. Although we see managers as occupying a privileged position in the processes of enacting policy, we need to read their descriptions, analyses and evaluations as discursive practices in which they articulate views of policy, staff, the public, government and 'the service' purposively. Our primary interest, then, is in how they construct consumerism and its relationship to the possibilities and problems of providing this service.

Policing: different voices, different choices?

As we saw in Chapter 3, the ideas and language of consumerism are less apparent in police policy texts than in either health or social care – a reflection, in part, of the comparative difficulty of realising the key consumerist idea of individual choice-making in a police setting (see, for

example, *Policing a New Century: A Blueprint for Reform* and *Policing: Building Safer Communities Together*, Home Office, 2001 and 2003). Compared to health care it is much more difficult to envisage a scenario whereby police consumers could be given a choice of provider, facility or type of treatment, a point attested to by one of our interviewees:

> We think the thing is … that the public actually as a rule have to take the service that they get, they can't actually go out and say, we don't actually like the way (*Local Force*) Police do this so I'm going to see if we can phone through and get (*Neighbouring*) Police to come and do it, because on such and such scales they deal with my type of incident in a far better way. (Newtown police senior 02)

In place of individual choice, police policy texts have tended to draw upon an alternative set of discourses focusing upon different aspects of the local, including conceptions of community choice, partnership and devolution (see Hughes, 1998, for a discussion of the discourses of citizen, consumer and community). Our interviews suggest that it is these conceptions that dominate the discursive landscape of senior police officers. While police policy texts may have minimised the idea of choice, they nevertheless incorporated some aspects of New Labour's consumerist agenda, aspects that senior managers have felt compelled to address:

> There are some cases now that are starting to happen where people do have a choice and the kind of things I'm talking about is if they're reporting racist issues and things like that, because say for example in (Newtown) there's something in the region of about 30 reporting centres and some of those will be police, but there'll be areas of worship, there'll be schools, there'll be other areas, housing offices etc. and they can actually choose who they report those to and what we're finding is that some of the communities would prefer to report it to their area of worship rather than actually report it to the police because they think that they'll be dealt with more sensitively (Newtown police senior 01)

As Crawford notes (2006 and forthcoming) the police have had to respond to a market where 'reassurance has become a commodity to be bought and sold' and they are not the only 'providers' responding to the public demand for security. It was clear that the senior staff we interviewed were well versed in the discourse of consumerism and could confidently discuss Government policy, having recently met with the Prime Minister,Tony Blair, for breakfast, had been in regular contact with David Blunkett, the then Home Secretary, or were on first name terms with Hazel Blears, then Police Minister. We asked interviewees about the ways they had incorporated 'consumerist imperatives' into their strategies. Most officers were clear about the meaning of the term but were less sure that it was being used, or was potentially useful for their organisation. As one explained:

> … in some ways, we're trying to open up the debate about looking at the public as consumers and having an understanding of what their needs are, and then in return for that being able to move from being what I describe as an ill-informed community to an informed community, then you can actually have some logic to your debate with them. (Newtown police senior 02)

Another explained that although the 'more senior people within the organisation' would 'appreciate' it, but:

> … we don't use the term consumer or consumerism but we all have our own ideas of what it means and to me, as a senior police officer, as the Divisional Commander, I do see our key partners, and the community, as people who consume the services that we can provide. (Oldtown police senior 03)

However, another senior officer explained the difficulties with regarding some of their users as consumers:

> Interestingly … if we're talking about certain sets of consumers, if we're talking about those that don't, wouldn't want to engage, i.e., the offenders that we deal with, our service has to be lawful, everything we do has to be lawful and so we've concentrated very much on that element of it whereas now we're starting to look at adding quality to that … (Newtown police senior 02)

This officer also reflected on whether – in the longer term – consumerism might turn out to have more far reaching implications for how policing might develop. Here there is a sense of disjuncture between the immediate focus on 'the core business' and what the business might become:

> … and for me the only thing is…you know…what is our core business and how do we crack on with getting things done and there may well be things within this world of changing use of consumerism that are very fundamental to how we police and that therefore become quite systemic and not just another flavour as it were. (Newtown police senior 02)

Treating the public as consumers and 'giving them what they want' presents the police with a number of problems. One critical element of many of the discussions of consumerism in this context was the senior managers' perception that the relationship between provider and service user in policing is quite different from that in either the private sector or other public services. In particular, they pointed to the uneasy intersection between consumerist ideas and the processes under which some people are *obliged* to receive services. Although such 'coerced consumers' are not only visible in policing – in social care, for example, statutory powers exist to enable public agencies to intervene in individual and family lives, where people are deemed to be a risk or at risk – our interviewees' preoccupation with this issue undoubtedly reflected the institutional centrality of the powers of arrest and detention:

> [S]ome of the actual business around consumerism, there's difficulty in transferring it from one arena to another … you know, squaring up to somebody in a situation where they don't want to talk to you as opposed to somebody selling them a tin of beans or trying to sell even double glazing. That is very, very different, and you know, there are lessons to be learnt but can't transfer directly. (Newtown police senior 01)

Senior managers' responses to the consumerist agenda were articulated in relation to its perceived 'fit' with other, ongoing processes of change. Again, the picture is a complex one, the consumerist agenda going 'with the grain' of some processes of change but colliding uneasily with others. An example of the former was the (ongoing) shift from 'force to service' (Johnston, 2000: 43). Our interviewees' acknowledged how this change facilitated recognition of users reconfigured as *customers* of the service:

> I think what the police are trying to do is to look upon the service that we provide, and compare it to what industry does in modern day, so we are trying to find a parallel to where we fit in with that. So whereas a few years ago we might have said we don't have customers, we are the police force, and that is what we do – we police the streets and keep order, we did not necessarily look upon people as providing a service to them and that they consumed our service. The changes have come, I think, the government stance, certainly in very recent years, sees the police, like any other public service, as strictly providing a service. (Oldtown police senior 01)

If the shift from force to service appears to have contributed to a 'consumer-oriented' re-conception of the relationship between the police and their users, the consumerist agenda's relationship with other aspects of reform had proved rather less straightforward. The following example demonstrates this clearly:

> [I]t's very hard to reconcile that idea [of consumerism] to the, sort of, performance culture that the police currently find themselves in, because, you know, I mean, I know we jokingly mentioned that there's nothing worse than a satisfied customer, and you know, police officers know that that's something that leads, compromises their business imperatives if you like, because in fact what happens is you can get swamped with all the problems of your satisfied customers, so in some ways, you know, ways we're trying to open up the debate about looking at the public as consumers and having an understanding of what their needs are and then in return from that being able to move from being, what I describe as an ill-informed community to an informed community, then you can actually have some logic to your debate with them. (Newtown police senior 02)

This extract reveals a perceived conflict between consumerist ideas and the *performance culture* established by the political centre (Clarke, 2005c). As Crawford and Lister report (2006) the purchase of a 'public good' such as policing, as in an initiative they describe in New Earswick, North

Yorkshire, not only leads to potential inequalities, but creates conflicts and tensions. In this experiment, residents believed they had their own 'dedicated' or 'purchased' officer and when local police managers had to move the officer from the 'duties specified within the commercial contract' (ibid.) for their own operational needs, 'purchasers felt they were not receiving the anticipated level of service'. For the officers we interviewed, the pressure on the police to meet government targets was seen as sitting in a problematic relationship to the application of a specific interpretation of consumerist ideas: a mix of community voice and community choice. In particular, our interviewees were unsure how, in the world of delivery – and in the context of nationally set performance targets – 'collective public consumerism' might be achieved. Certainly their frequent reference to 'community' speaks to the weight of that discourse in policing, and yet senior managers were extremely hesitant about the wisdom of listening to community voices or acting on community choices. Our interviewees returned to worries about 'ill-informed' communities' wants, expectations and choices – as opposed to the police's interpretation of needs – driving change. As in the field of health care, there were persistent issues about the relationship between different sorts of knowledge – in particular, organisational and occupational expertise – and decision-making power:

> Because sometimes what you can have, is you can have consultation with a community that in fact don't know what they're talking about and therefore you know, if that's the validation of your policy you can actually be very, very compromised later on by going down an avenue which you have actually responded to maybe a pressure group, or maybe a group that's totally ill-informed. So it's a way in to a community but you've got to be really careful about how much leverage you allow that to have on the organisational goals until you've got a really stable relationship with them. (Newtown police senior 02)

So it seems from these discussions that Government directives about public or collective choice did not figure at the head of the local police agenda. We were interested in how institutional adaptations of Government agendas was communicated to the people on the ground and one of the Oldtown officers explained:

> It works in the simplest of ways, by very senior officers from this force very often having to go to London to find out what the brief is, what is expected of us, coming back and briefing people like myself as divisional commanders, we have to go then and make sure that our division delivers, we are answerable at a performance review process in the force, that every month we look at our performance across the board, and likewise the Chief Constable is answerable to the Home Office … So you've got a very critical, a very close monitoring of performance, and performance against targets … it actually relates to burglary dwellings going up or are they going down, where are the worst places in the city, where are the worst areas for it, what are you doing about it, who are the worst offenders and what are you doing about them, have you targeted them, and we are expected to

> know that detail then, whereas a few years ago somebody in my position would be seen as the strategist who sits above it and wouldn't need to know all that detail … Whereas now that personal lead is given by the Prime Minister, and even this debate in the last few days about his health, many would say it is because he is too intrinsically involved in all the minor issues, about what is going on, but this reflects down to Chief Constables and Chief Superintendents. (Oldtown police senior 01) (The interview refers to a period in which the Prime Minister had a much discussed minor heart operation.)

This officer saw organisational objectives as being more directed by the choices of Government than by those of local residents. If the shift from force to service appeared to have enabled a 'consumer-oriented' reconception of the relationship between the police and their users, the consumerist agenda's relationship with other aspects of reform had proved rather less straightforward. One of these difficult intersections occurred between the consumerist imperative and the attention New Labour was (during the middle part of 2003) paying policing and its 'performance':

> But we are judged more on leadership, and my division has recently had a HMIC inspection, via … Her Majesty's Inspectorate of Constabulary, it has already been published this week, and the two main issues that they are looking into are performance and leadership, both of which are critical … it is a pressure, the pressure to succeed, the pressure to reduce crime, because the feeling is that if you don't reduce crime there is always somebody who is ready to pounce upon you and literally, the power to remove Chief Constables and ultimately BCU commanders such as myself if we don't do our job correctly. Now, that might not be something that is involved every two minutes, and it clearly isn't, but it is the sort of thing … we are under intense scrutiny. (Oldtown police senior 02)

These pressures seemed to be more focused on traditional 'core' policing issues such as reducing crime, rather than customer service in a public problem-response sense that was emphasised in the policy texts cited earlier. Being judged by quantifiable 'results' still seemed to be at the heart of the message New Labour was delivering to police via senior strategy officers, or at least this is the one they were hearing. Perhaps the choice agenda was too nebulous a concept to be measurable in police performance terms, or perhaps, as the extracts above suggest, the diversity between 'them and us' as the unwilling customer, or unreasonable demanding 'uneducated' public or the undeserving victim is still a large gulf to cross. Culturally perhaps, the public service 'crime fighters' as opposed to the healers or carers may have further to move if their view of the customer or consumer is to be altered radically.

Social care: supporting choice?

Social care has its own distinctive institutional formation and trajectory. Its organisational dimensions have been dominated by its place within

local authorities (social services departments, or social work departments in Scotland). Occupationally, social care has been dominated by the mediating or bureau-profession of social work, even though most of its staff were not professionally qualified (Clarke, 1996). Both of these axes have been the subject of extensive and persistent challenges and pressures for change since the creation of local authority departments following the Seebohm and Kilbrandon reports (Clarke, 1993). However, social care has also had a less distinct institutional identity than either health or policing: problems of defining social care, social services and social work have a long history. It has also had rather more blurred relationships with the public (as potential users of its services).

In common with health, social care has seen an increasing emphasis on a consumerist or choice orientation (see, for example, the shifts from *Modernising Social Services* through *Fair for All and Personal to You* to *Independence, Well-being and Choice*, Department of Health 1998, 2003a and 2005b). Asked in broad terms about a 'consumerist imperative', our interviewees agreed that this was something to which social care organisations have had to adapt. At the same time, however, they argued that this process of adaptation was not a recent phenomenon but part of a longer term trajectory of change, beginning with the 1990 NHS and Community Care Act. For some, the idea of choice – here articulated as the diversification of provision – had played an important role in shaping this changing relationship:

> Well choice is not new you see. With the 1990 NHS and Community Care Act and what the then government was pushing was that they gave the local authority, um, the task of assessment, didn't they, for private nursing and residential care. Now all that was about choice, so basically what I think social services, um, we've accelerated this really, um, yeah. You could say, um, in the past most of the services that we've delivered have been in house but certainly that act exploded the situation … That act I think triggered the beginning of the end in terms of the majority of services from Social Services… So people, um, will be able to choose from the private, the voluntary or our in house services or any combination … (Oldtown social care senior 02)

Others identified the significance of the 1990 Act as a critical turning point in relationships between service users and providers:

> Er, I think that imperative has been around for a long time. Um, I would say since the – in social care terms – since the NHS and Community Care Act 1990, where I think there was a focus on listening to the views of service users and carers in doing new assessments. And within that legislation there was the choice directive – for example, for residential care. So, and I think similarly in um, you probably can't say when it started but that's been a growing thing throughout the nineties, probably in the eighties as well but especially nineties. And certain other bits of legislation – Disabled Persons Act, Carers Legislation, our policy like the valuing people, people with learning disabilities. Um, a lot of mental health policy and guidance – nearly right up to national service

> frameworks for older people, mental health etc., they all have this emphasis on putting carers at the centre. I think particularly in the last three or four years where we've used terms like person-centred care, person-centre planning, um, so I think that focus has been there for a long time but it's got more focused and more specific in recent years. (Newtown social care senior 07)

In their observations, people constructed different readings of this history that begins with the 1990 Act. But questions of challenge and responsibility were identified as things to which social care organisations had (more or less) successfully adapted. As a result, current initiatives were, to a large extent, seen as going 'with the grain' of the institutional formation and trajectory of social care. One dominant theme was that – even if the language is difficult – social care services had been substantially transformed to a more user/person/customer centred mode of working during the last decade. These managers viewed this as a positive development. But it was not a story without problems or disjunctures. There were some recurrent themes in how social care managers spoke about delivering social care in a more consumerist environment that centre on the difficult relationships between resources and priorities (taken up further in Chapter 6). Social services departments have, since their inception, encountered problems about managing the relationship between demand and resources (as do most public services). But they perceive the will to create more choice or more options as unreasonably constrained by the availability of resources – frustrating both them and (would-be) users. Many of our interviewees circled round how choice was to be exercised in a context where resources were perceived as always falling short of need. One manager expressed it pungently:

> I'm saying that this thing about choice, when you don't have any resources to deliver choices, is a complete red herring because quite frankly there isn't the choice. The choice is you take it or leave it really … And you know, I've got a budget and I've also got government guidance that really encourages choice, you know, positively encourages it but I think what I was saying is there is certain areas of provision where there isn't the choice. You're so constrained by resources. There's also things like you know, you can't really choose what time somebody comes round to get you up because you're so constrained by the lack of people. And especially in [Newtown], you've probably heard people talk about it being an economic hotspot, there simply aren't the workers to be able to deliver that choice. You know, you're setting up things to fail. (Newtown social care senior 07)

As a group, the senior managers we interviewed were preoccupied by the ways in which resource shortages were constraining their ability to offer choice to users of the service. In turn, this preoccupation shaped their approach to the choice agenda in various ways. First, there was a great deal of emphasis on the need to be 'honest' with service users about what they might reasonably expect from the service. Our interviewees clearly perceived it as necessary to expend significant amounts of time

and energy – both managerially and on the front-line – managing expectations and demand:

> [Y]ou have to be up front and honest with people, and say that's within a financial envelope, so the world is not our oyster, we can't say you can have what you want, but what we can say is that, that is what we can spend, or what we can allow you to spend through direct payments if that is the road they're going down. These are the services that we have got available. (Oldtown social care senior 01)

If expectation management constituted one response to the difficult relationship between choice and resources, an emphasis on individual needs – assessment was another. Our interviewees were very preoccupied with the question of needs and had clearly spent time pondering how responding to needs – rather than wants – had a constraining effect on the implementation of the choice agenda. The following extract explicitly recognises that it was only when individual assessments were put together – again, on the basis of needs rather than wants – that offering choice became a consideration:

> Yeah, what I am always clear to say to staff is that when we talk about choice, we need to be clear about what those choices are and particularly I find it difficult with elected members when they are responding to constituents. I want a home help, I want this, I want that, and they keep saying to them nobody can have anything until we have done the assessment, we have to identify that there is a need. Only once we have done that and recognised that we need to put a package together, then that is when the choice comes in. (Oldtown social care senior 01)

A further complication noted by our interviewees stemmed from the inevitability of different definitions of need and the associated question of rights. Definitions of need have, of course, been long contested by groups using social care services; at the same time they have pointed to the conflict between needs and rights whereby the process of needs assessment renders rights to services conditional and contingent, rather than universal and absolute. This leads us into the problem of inequality. Talking about this issue, our interviewees frequently echoed their health care counterparts in drawing a clear distinction between the wants of the informed, articulate consumer and the needs of the relatively disadvantaged. In the following extract, consumer demands were represented as a threat to the objective assessment of need; if demands took precedence over need assessment the likely result, it was argued, would be inequitable distribution:

> I think the problem at the individual level is that the more articulate and the better informed who are often the more middle class and wealthier consumers, um, are able to advocate for a better deal. And that, um, you know there's no reason why everyone shouldn't advocate for a better individual deal but given

> our job is to manage to provide the best possible service within, um, available resources, part of a local government job is trying to use the available resources equitably. And there is the possibility that by individual consumers advocating strongly that they actually upset that equitable distribution which is meant to be based on need, you know targeted based on their need which is where assessments is meant to be a sort of objective judgement of different levels of need. And if someone with er, less needs advocates more strongly and gets more resources then inevitably other people get less resources somewhere along the line. So I think there's that pressure – those competing aims really. Um, I think there's a similar potential pressure in relation to different, um, service user groups because clearly children's services to a certain extent because of public scandals, have – are able to claim more resources. And I think, um, certain strong consumer movements which may well be carer and professional advocacy lead, um, are always trying to increase the sort of percentage of overall resource available to their particular group and so there's … almost this competition between different groups in terms of, you know, where the resources should go. (Newtown social care senior 04)

As with policing, there are issues about the relationships between services and unwilling 'service users'. Our interviewees pointed out that not all users of their services actually *choose* to be such at all, but rather find themselves obliged to receive services. Although compulsion is certainly less visible in social care than in policing, the existence of 'coerced consumers' – deemed to be at risk or a risk to others – was repeatedly highlighted. Likewise managers pointed to the existence of 'reluctant customers' whose decision to access social services is not so much a positive choice as a reflection of constrained financial circumstance:

> [T]he concept of customer assumes that somebody is coming to you because they wish to. In the mental health field, in abuse situations, people are not always coming because they want to, they're being forced on their doorstep. (Oldtown social care 03)
>
> Consumerism, well, I suppose consumerism, again, is about having the money to buy what you want. And, um, although growing numbers of people who use our services have the money to take different paths and use different choices they don't come to social services through choice in a sense. They come to social services because they have certain things happening which we can work with them to help them either understand or to organise services that will help them through that period of time. But, you know, if you've got half a million quid in the bank you don't necessarily want to come anywhere near social services. You just go and sort it out for yourself and pay the bill. (Newtown social care 06)

These last extracts return us to questions about equality raised in Chapters 2 and 4, and suggest other limitations of consumerism as the dominant template for reform. They also remind us that other dynamics and relationships have to be reconciled in professional responses in a myriad of what, in Chapter 4, we termed 'unpredictable encounters'.

Health care: making choices?

Interviews with senior managers in the two Primary Care Trusts (PCTs) demonstrated that they had, by far, the greatest preoccupation with the idea of choice. PCTs had a double function in the NHS. They provided non-hospital health care services – co-ordinating General Practitioners and other providers. They also took responsibility for the health strategy for their locality, including commissioning hospital services from Hospital Trusts on behalf of the public of their area. These managers clearly felt compelled to address the idea of choice, but were nevertheless busy reframing and reinterpreting it in a variety of ways. The unresolved tensions at stake in these processes of translation were summarised thus by one interviewee:

> It depends… what you mean exactly by choice, whether there is a choice to be had in that particular area, and actually who that choice is ultimately going to benefit. (Newtown health care senior 02)

The meaning of choice varied considerably in our interviewees' reflections, with managers emphasising different aspects of the choice agenda and relaying different accounts of motives, means and ends. Accounting for these differences, one might point to a range of factors – not least, for example, interviewees' divergent professional backgrounds – but particularly significant was how they conceived the interaction between a consumerist agenda and other, ongoing processes of change within health care. Take, for example, choice of hospital, a central plank of the government's choice agenda, and one flagged up by several interviewees albeit in a way which routinely failed to echo the government's consumerist discourse. Policy texts consistently advocated choice of hospital as a *powerful tool for increasing responsiveness and consistency of high quality care* (Department of Health, 2003b: Chapter 3, Para. 49). In practice this aspect of choice tended to collide with – and be reinterpreted against the background of – senior managers' ongoing preoccupation with government targets on waiting times:

> Obviously, the first requirement for patient choice is, any patient that has been waiting more than six months, at the end of April should be offered a choice of provider… this is almost a punitive measure, to make sure that patients are seen within six months, so we think it is a backdoor way of decreasing waiting times even further. (Oldtown health care senior 03)

> [T]here is a government initiative at the moment called choice and that's for patients who have been waiting for longer than six months for surgery, they are then given a choice as to where they would like to go to have that surgery... The hospitals benefit because they don't breach their targets, or the PCT don't breach their targets. You get severely penalised if you have patients waiting for longer than six months, your Chief Exec's job's at risk … that's the sort of thing that you would be star rated against. (Newtown health care senior 02)

Such comments may be read as a calculating evaluation of one of the government's key initiatives on choice, but we do not wish to paint a picture of cynical resistance to the consumerist agenda (cynicism and foot-dragging reluctance being charges often levelled by New Labour at public service workers and professionals). Indeed, while interviewees clearly rejected the notion that introducing choice would be in any way straightforward – or without potential drawbacks – they were nevertheless engaged in serious attempts to engage with a consumerist agenda. On the one hand, interviewees were busy dealing with the practicalities of introducing choice, reorganising commissioning processes, redesigning internal systems and realigning their organisations to compete in the new environment. On the other hand, our interviewees were actively re-conceiving the relationship between professionals and patients, often appropriating particular aspects of a consumerist agenda in the process, in order to secure the professional goal of improved clinical outcomes.

Here we wish to focus on just two key re-conceptions of the relationship between professionals and patients. The first centres on a fundamental reworking of the choice agenda – away from choice of hospital and towards the idea of patient involvement in treatment decisions:

> [I]f you talk to people about choice, a lot of people will think 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 which hospital you go to, it's around how do you want the service delivered to you, so once you have been diagnosed with cancer it is around saying that there are these options available for your support which will fit you best? There are these options available for treatment, which one fits you best? (Oldtown health care senior 01)

> [P]art of, um, part of delivering any choice agenda well has got to be also to provide patients with information about the… different options that are available to them. And I'd like to think that the options available to them aren't always just that you have to – you've got to have an operation and here's the choice of where you go to and these are the outcomes in these different hospitals for what they do. It's even more than that. It's about 'Well Mrs X you've got – you know, you've got this condition, you've got this problem and the options are we work with you to manage the pain better or we work with you through diet and exercise to minimise the damage that's been caused. Or alternatively you can opt for surgery and if you opt for surgery these are the risks, these are the benefits, these are the outcomes and the different providers that are offering this care'. So I think it is much more sophisticated than perhaps it's projected in the newspapers. (Newtown health care senior 04)

These extracts reveal ways in which senior managers were attempting to engage with the government's choice agenda, and to render it meaningful within a particular service context. Our interviewees had moved away from the idea of choice as being about a choice of provider, and towards a more professionally established – and acceptable – notion of choice as

involvement in treatment decisions. The hoped-for relationship between patients and professionals was described by one respondent – using a (very consumerist) shopping analogy – as a partnership:

> [W]e all know the shops we enjoy shopping in and it's ones where the, um, assistants get the right balance between offering to help but not intruding too much and sort of like frogmarching you round the dresses or the tins of beans or whatever it is. And, um, so in health care I think that's what we've got to work at, getting that right, getting the partnership between patients and their care givers right as opposed to what was previously a rather patriarchal or matriarchal way of doing business with them. (Newtown health care senior 04)

Interviewees understood this conception of the relationship as a partnership in very specific ways. As the above extracts imply, the role of 'ideal' health professional was to act as a helpful (knowledgeable) guide around the various treatment options; here, partnership was certainly not used to imply *equal* partnership. Likewise, this model of the patient as involved partner stands at a significant conceptual distance from the figure of the demanding consumer. The latter rarely surfaced in our interviews – when they did, interviewees tended to view them as a source of difficulty:

> 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. (Newtown health care senior 01)

Interviewees' concerns about the best ways to deploy finite resources and set priorities also extended to other anxieties about the implications of the choice agenda. Whereas New Labour policy promoted choice as a way of raising standards across the board, senior managers retained very real concerns about the relationship between choice and inequality in their locality:

> I mean my slight worry with this is that choice will only be exercised by people – well, from the middle classes. I hate using that term but it's the best quick description, um, because they will be able to articulate and demand what they want. (Newtown health care senior 04)

These concerns about how to balance choice, needs and resources were voiced repeatedly across all the three services we studied. For service managers, one of the critical differences between public services and markets was that demand implies costs, not just income – accordingly, demand was something to be managed, rather than stimulated. Similarly, the history of class advantage being reproduced in and through public provision suggests the anxiety about who gets to exercise choice – or whose choices are realised – was a reasonable concern to raise in relation to the consumer/choice agenda.

The concept of choice, then, provided a bridge between professional and consumerist discourse. It was welcomed where it could 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 was rather different from the idea of choice as elaborated in government policy. In professional discourse, choice meant involving patients in decisions about appropriate treatments in the interests of more effective health outcomes (rather than giving a choice of provider, for which, as several of our interviewees pointed out, service users had inadequate information in any case). 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 the popular TV series *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 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.

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 health care senior 02)

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 was a very different narrative of change from those highlighted in the policy statements: community needs, rather than consumer demands, were viewed as the driving force and staff are acknowledged as a critical resource.

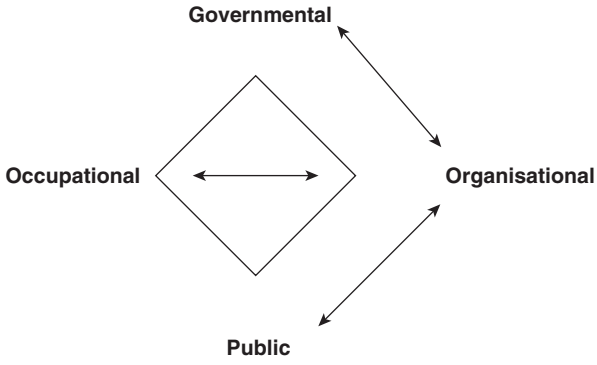

Figure 5.2 *Multiple pressures*

Managing consumerism: different trajectories, common themes

We have explored how service organisations are adapting to consumerist imperatives in different ways. To some extent, these differences reflect the different policy injunctions from central government, but these injunctions are made sense of, interpreted and translated within the particular institutional formations and trajectories of the three services. One important element of this study has been making these differences visible – rather than talking about public services in general. At the same time, however, we can trace some common themes across the services. We will take up some of these in the following chapter, but before doing so we return once more to the diamond framework to consider the dynamics of institutional adaptation:

In this chapter, we have been foregrounding senior managers as representing the 'organisational' point of this diamond and negotiating relationships with the other points – the 'stakeholders' of public services: government, staff and the public. Most also bring with them occupational identities and professional histories that shape the ways in which they seek to influence the process of institutional adaptation (Newman, 2005c). But their capacity to do so is in turn shaped by other dynamics as they relate both to government and to the public itself. In relation to governmental pressures, we have seen two dynamics of adaptation – the process of translation of policy into practice; and the reconciliation of consumerist imperatives with other governmental demands for service 'performance'. Each organisation was the site of active interpretation of governmental initiatives, attempting to bring them into alignment with the institutional mix of local, occupational and organisational trajectories. Such processes of inflection, interpretation or translation are also sites of recurrent governmental frustration, leading to a search for the 'levers' that will ensure

the implementation of governmental objectives. The multiplication of control devices (legislation, guidance, incentive systems, reporting systems, inspection and audit) is, in part, a testimony to the 'loosely coupled' nature of implementation, not least in an era in which devolution, decentralisation and local autonomy are also supposed to be key elements of modern systems of governance (Newman, 2001).

The space for interpretation in the process of implementation can be seen as arising from the coincidence of several features of public services. First, the complex system of apparatuses, agencies and agents through which policy is delivered involves such spaces. The organisational complexity of systems of governance in public services – combining different layers or levels, different spatial formations, different sorts of organisations and different sorts of expertise – produces an institutional architecture in which 'levers' have a hard time connecting central government and front-line staff. If anything, the last three decades of public service reform have made this architecture more, rather than less, complex through processes of marketisation, contracting and partnership that produce multiple organisations engaged in service delivery (Clarke, forthcoming b).

Secondly, the 'wriggle room' for interpretation is opened up by the existence of multiple objectives demanding the attention and resources of public services. The literature on public service management treats this as a characteristic feature of public service organisation, marking their difference from the 'bottom line' focus of private sector bodies (e.g. Ferlie et al., 1996; Flynn, 1997; Pollitt et al., 1998). Some of these multiple objectives derive from explicit policy imperatives – visible in discussions of crime or waiting list reduction targets, for example. But these governmental objectives have to co-exist with others: more informal, local or organisational pressures for results, requiring organisations to promote their own legitimacy and 'success' to other stakeholders. Organisations have been quick to understand the potential value (as well as risks) of discourses of decentralisation and devolution. They also recognise governmental ambivalence about local autonomy – and how constrained it is by the growth of national evaluative systems (Clarke, 2005c).

Our analysis also shows how each of the services has concerns about how to align the occupational axis with the demands and pressures of consumerism. Staff – their skill mix, their orientation to the service and to the public, and their engagement in the corporate culture – form a critical focus of organisational management. Managers are conscious of the different demands – the need to 'modernise' the organisation; the need to 'get people on board' to ensure a successful, high-performing, organisation; the pressure to engage with the public in more productive ways; and – by no means least – the pressure to engage with the professional values and ethical orientations of public service staff. As we have seen, consumerism is both a pressure for some of these developments and a disruptive force.

Finally, all of these organisations were in the process of reviewing, rethinking and remaking their relationships with the public. None of them were wholly at ease with a conception of the public as 'consumers' of their service but all recognised that consumerism marked some thing more than just another governmental 'initiative'. Relationships with the public were in flux – uncertain and unsettled. Encounters between services and their users could not be framed as the providential meeting of expert authorities and grateful supplicants. We are not wholly convinced that this was ever true – but the dynamics of deference, compliance and dependence may have formed a potent cocktail that kept people in their place. Organisations providing services know that the apparent stability of provider-user encounters cannot be relied upon. Some users are now 'experts of their own condition'; some are assertive 'rights bearing' subjects; some are insistent 'consumers' – while others may be patient patients, quiescent users of services or compliant in their relation to professional expertise. The possible dynamics that govern provider-public encounters have multiplied, and make for a more unpredictable field of possibilities. We will return to some of these issues in the following chapters.