What's in a name? New Labour's citizen-consumers and the remaking of public services

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The reform of public services in the UK has been driven – in part – by a conception of citizens as consumers of public services, a conception which is lodged in narratives about the wider social transition to a consumer society and consumer culture. This paper explores the political and policy discourses of the citizen-consumer. We examine the conditions, condensation and consequences of this hybridised identification in the context of New Labour's political and governmental project.

Our data is drawn from a recent research project which examined the shift towards a consumerist orientation in policy about public services.[1] It explored the ways in which this was situated in political narratives legitimising the modernisation of the social democratic welfare state, and how such narratives attempted to address fundamental tensions in New Labour's political project. We studied the ways in which the consumerist orientation was being interpreted and enacted in three services (social care, health and policing) in two locations (Oldtown and Newtown), highlighting ways in which consumerism is articulated with professional and organisational discourses as public services seek to address the contradictory imperatives of modernisation (see, for example, Clarke, 2004; Clarke, Vidler and Smith, 2005; Newman and Vidler, forthcoming; and Vidler and Clarke, forthcoming).

Citizens or Consumers?

For advocates of consumerist approach to public service provision – and for their critics – the relationship between citizen and consumer identities is an antagonistic one. For example, the National Consumer Council's Policy Commission on Public Services concluded that:

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We studied three public services (health, policing and social care) in two places (Newtown and Oldtown). We distributed 300 questionnaires (returns from 106 users and 168 staff = 46% return rate). We conducted 24 interviews with managers; 23 with front-line staff; 10 with users and held 6 user focus groups.
The project team was John Clarke, Janet Newman, Nick Smith, Elizabeth Vidler, Louise Westmarland, based in the Faculty of Social Sciences at The Open University, UK. More details at: www.open.ac.uk/socialsciences/citizenconsumers.

> In this debate, traditional concepts of 'citizenship' are problematic. Engagement and trust in the electoral process is declining, and voting rights confer limited influence over the direct provision of services. Alternative ways of ensuring voices are heard are required… If public services are to respond to the plurality and diversity of consumer demand, the catch-all term 'citizen' is unhelpful when it assumes there is a homogeneous 'citizen interest'. The Commission suggests it is more helpful to think about the plurality of individuals as consumers, stakeholders and individuals concerned with the wider public interest. (NCC, 2004: 10)

For critical commentators on the consumerist orientation, however, it is the combination of homogenization and individualization represented by the 'catch-all term' consumer that is problematic and unhelpful. David Marquand, for example, links the enthusiasm for consumer/customer focus to wider dynamics of public service and political transformation:

> New Labour has pushed marketization and privatisation forward, at least as zealously as the Conservatives did, narrowing the frontiers of the public domain in the process... Ministerial rhetoric is saturated with the language of consumerism. The public services are to be 'customer focused'; schools and colleges are to ensure that 'what is on offer responds to the needs of consumers; the 'progressive project' is to be subjected to 'rebranding'. (2004: 118)

In part, this debate persists because the figures of the citizen and the consumer stand for much wider social, political and philosophical conditions. Indeed, they might be said to embody a powerful and persistent binary distinction between the state and the market (a binary shared by neo-liberals and social democrats, even if their evaluation of the relative terms is different). As a result, the distinction between the citizen and the consumer carries a whole series of subsidiary binaries: public/private; collective/individual; de-commodification/commodifiction and so on. The binary also seemingly condenses temporally divergent images of the social: the 'old' social of collective identifications and citizenship rights and a 'new' social of individualised and consumer oriented identifications. Our concern here is not top pursue these binaries, but to note their salience for understanding the levels of investment in the debate that surrounds them.

In political and policy discourse, things have been rather less clear cut than the citizen-consumer distinction might suggest.[2] Both terms and a cluster of others continue to circulate in policy texts and in political statements about public services. An exemplary version was provided by Tony Blair in 2004:

> In reality, I believe people do want choice, in public services as in other services. But anyway, choice isn't an end in itself. It is one important mechanism to ensure that citizens can indeed secure good schools and health services in their communities.

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[2] Indeed, one of the striking features about New Labour is its enthusiasm for citizens and citizenship. It might be seen as a political and governmental project that has proliferated varieties of citizenship (and their rights, responsibilities and locations). Some aspects of this phenomenon are discussed in Clarke, forthcoming.

> Choice puts the levers in the hands of parents and patients so that they as citizens and consumers can be a driving force for improvement in their public services. We are proposing to put an entirely different dynamic in place to drive our public services; one where the service will be driven not by the government or by the manager but by the user – the patient, the parent, the pupil and the law-abiding citizen.
>
> (T.Blair, quoted in *The Guardian*, 24/06/2004, p. 1)

So, here we see a very mobile set of identifications – citizens, consumers, parents, patients, pupils and – an interesting qualifier – 'law-abiding citizens'. Policy documents, too, make use of this vocabulary. There is no simple displacement or banishment of the 'citizen' in the shift to consumerism. So, how is this consumerist tendency to be discerned and made sense of? One starting point is with the contextualisation deployed in almost all of the policy sources and New Labour statements about public services. Their anachronistic character – the thing that make their reform necessary so that they can take their place in the 'modern world' – lies in the disjuncture between them and the wider social transformations, in particular the rise of the consumer society:

> Rising living standards, a more diverse society and a steadily stronger consumer culture have… brought expectations of greater choice, responsiveness, accessibility and flexibility (Office of Public Service Reform, 2002: 8).

A second would be the increasing salience of the concept of 'choice', as expressed in the Blair statement quoted earlier. Choice has a distinctive double role to play in New Labour's approach to public service reform: it is simultaneously 'what people want'; and a mechanism for driving improvement:

- It's what users want
- It provides incentives for driving up quality, responsiveness and efficiency
- It promotes equity
- It facilitates personalisation (Ministers of State, 2004, p.4)

Choice has become the key term – drawing more and more services into its ambit (see, for example, the recent Green Paper on adult social care: *Independence, Wellbeing, Choice*; Department of Health, 2005). Choice is primarily understood in this view as what the NCC Policy Commission called 'economic choice [which] is the kind exercised in market' (2004: 26). They note that non-economic choice models and voice are also important. But the imagery (if not always the precise mechanisms) of choice that pervades New Labour discourse on public service reform is derived directly from the market model (competition between providers; choice exercised by a 'sovereign' consumer in pursuit of individual wants).

So what is going on in this discursive dance around citizens or consumers, citizens as consumers, and even citizen-consumers (see, for example, Reid, 2004: 'We can be citizens and consumers'). In the process of condensation into the hybrid form 'citizen-consumer', however the 'old' social becomes transformed around an image of citizenship that is apparently more compatible with modern images of state-citizen

relationships, while 'consumer' is strongly associated with choice. Stuart Hall has written about this process of hybridisation and transformation in New Labour, using Gramsci's idea of 'transformism':

> New Labour is confusing in the signals it gives off, and difficult to characterise as a regime. It constantly speaks with a forked tongue. It combines economic neo-liberalism with a commitment to 'active government'. More significantly its grim alignment with the broad global interest and values of corporate capital and power – the neo-liberal, which is in the *leading position* in its political repertoire – is paralleled by another, *subaltern* programme, of a more social-democratic kind, running alongside. This is what people invoke when they insist, defensively, that New Labour is not, after all, 'neo-liberal'. The fact is that New Labour is a *hybrid* regime, composed of two strands. However, one strand – the neo-liberal – is in the dominant position. The other strand – the social democratic – is subordinate. What's more, its hybrid character is not simply a static formation: it is the process which combines the two elements which matters. The process is 'transformist'. The latter always remains subordinate to and dependent on the former, and *is constantly being 'transformed' into* the former, dominant one. (2003:19).

For various reasons – not least the data from the project that we are going to discuss shortly – we would want to emphasise the 'constantly being transformed' part of the last sentence above. Transformism is not a once and for all process: like all practices of articulation, it is vulnerable to the possibilities of rearticulation by other positions, whether the residual formulation of citizenship or emergent reinventions of both citizens and consumers (as ethical consumers, for example). New Labour works hard to make its imagined modern world – and the subjects to people it – come true, but hard work is no guarantee of success. We have written about New Labour's construction of citizen-consumers at greater length elsewhere (e.g., Clarke, 2004), here we want to concentrate on the ways in which people identify themselves in relationship to public services.

Identifications and Relationships

This paper takes as its theme the *changing identifications and relationships* taking place in the intersection between public services and the people who use them, drawing on data from health service users. We collected this data in several different ways. First, we distributed a questionnaire to 50 randomly selected users in each of our two urban settings. The final question asked respondents to consider a number of possible identifications and relationships (citizen, consumer, member of the public and so on) and to select those that they felt best reflected who they thought they were when interacting with the service in question. They could select more than one category, and most did so. They were then invited, on the questionnaire itself, to add comments about why they had chosen particular categories. This gave us an initial set of quantitative and qualitative data.

We then used this data to design semi-structured interview schedules to test some of the emerging themes, and carried out follow up interviews with respondents who had indicated their willingness to be interviewed. The interviews, then, are not based on a random sample – they possibly represent those with more time and commitment than

the norm. However we found very similar themes emerging from the questionnaires and interviews: the interviews, then, allowed us to explore in further depth themes that were already emerging from the questionnaire data. Finally, we held focus groups in each case study site drawing on members of local patient and public participation groups. These were not 'representative' of the general population but individuals were very well networked into wider groups of service users and did seek to represent their views. But they were inevitably closer to professional practice and tended to use 'insider' language – for example the language of patient empowerment – more readily. They were also more aware of, and reflective about, current changes in policy and practice, as well as what they perceived to be shifting user perceptions and aspirations.

We are currently trying to make sense of this varied data. In what follows we identify a number of themes emerging from the survey data and then attempt to unpack a selection of the interview and focus group quotations in order to open up a discussion of how far 'words matter' in the shaping and /or performance of identity, and in the formation and reformation of relationships between the public and public services.

Neither consumers nor citizens?

The survey results suggests that, despite the current prevalence of consumerist discourse in policy texts and political speeches, it appears not to be very significant in the language people who use health service adopt to talk about themselves:

TABLE 1

Consumer	**3**
Customer	**3**
Patient	**30**
Service User	**23**
Citizen	**5**
Member of the Public	**20**
Member of the local community	**13**
Total	**97**

These results are significant in a number of ways The limited identification with consumer and customer is striking, but so, too, is the limited identification with citizen. Is it possible that the 'big binary' citizen/consumer so central to political discourse (and political science) lacks any substantial popular reach around public services? By contrast, what we might call 'service specific terms' – expressing a relationship to a particular service – have a much greater reach.

But the other popular terms are ones that invoke a sense of 'membership' - relationships of belonging in which people are part of something, and feel that services do – or should – belong to them. Larger collective imaginaries – the public and the local community – both carry this sense of longing and attachment.

The questionnaires suggested that people are well able to hold different identifications alongside each other, but that these are mobilised depending on the context and nature of specific transactions. We looked at the different forms of hybrid identifications evident in the 'comments' section of the questionnaire. First, four responses from Newtown attempted to reconcile consumerist with other forms of identification:

> *I find it very difficult to answer as I would like to feel I was a consumer as I have paid for my treatment. Unfortunately I still feel a patient and as though there is a long way to go before the general public realise we pay for this service and have rights to demand a better service (Newtown health user 32: no selection).*
>
> *The NHS is like any other service provider, public or private. I am therefore a customer forced to use the service but with no opportunity to take most of my custom elsewhere. The private sector does not provide many of the products only available from the NHS (Newtown health user 21: customer and service user).*
>
> *I have many relatively serious conditions, and, therefore, am most definitely a patient. But I am also a consumer, having paid NI contributions for many, many years (New Town health user 34: patient).*
>
> *I can and have been a patient and if and when I use my doctor or hospital I suppose I am a customer. As I have paid NI cons for 45 years I hope I'm a valued contributor and customer – there is a doubt in my mind though! (Newtown health user 11: consumer and patient).*

Interestingly only one of these – the second – uses the term customer to open up questions of choice; the others interpret 'consumer' or 'customer' as something linked to the rights of citizenship associated with paying NI contributions or taxes. The state/market binary is, then, only very weakly reflected in a duality between citizen and consumer: most responses stay firmly positioned on the 'state' axis. The identification 'patient' was much more prevalent than those of consumer or customer terms often explicitly rejected:

> *Patient is the traditional term and I think it is still appropriate. The NHS is a service to users (in the local community). I know 'consumer' and 'customer' imply choice and that is what we are supposed to want. I would consider it an acceptable achievement if everyone could have what was best in the matter of treatment as of right. There are certain cost considerations but that is another issue). 'Choice' may be a political ploy to take our eye of the ball and confuse us as to what really matters. Choice sounds a good thing – but is it? Sorry, this is one of my hobby horses! (Newtown health user: patient and service user)*
>
> *Consumer/customer do not fit as I do not 'buy'. Service user is politically correct psychobabble. Citizen is not a word that appeals to me. When I need treatment I am a patient, when I do not I am a member of the public (Newtown health user 33: Patient and Member of the Public)*

This hybrid forms 'patient' (or sometimes 'service user') and 'member of the public' (sometimes 'member of the local community') were by far the most common combinations. But they were linked to rather different conceptions of 'patient' or 'service user': some dealt in conceptions of dependence and need, while others suggest a more assertive, knowledgeable or self-reliant image, closer to that found in current policy and professional discourse. As might be expected, the association between dependence and patient-hood was more common in Oldtown than Newtown, but this was not always the case:

> *I am a user of the NHS service when I am in need of it. I consider a patient to be someone who is more intensely dependent on the NHS. I like to be involved in making decisions about my healthcare, and question 'professionals' when I feel the need: yet I don't feel autonomous enough to be labelled a 'customer' or 'consumer'. (Oldtown health user 20: service user and member of the public)*
>
> *I have a chronic illness and have therefore been treated by the NHS over a long number of years. I feel involved in my case, but am nevertheless very dependent upon the care given by professionals – doctors and nurses. This relationship – doctor/patient- is right for me, and I feel more than a consumer or customer. I am also very involved in the more recent patient involvement/enablement programme and view myself as a member of the public, putting forward the view of the ordinary patient (Oldtown health user 11: patient and member of the public)*
>
> *Service user – this is a two way partnership between person who is ill and the medical adviser.*
> *Member of the local community – because I am concerned about the quality of this public service for all its users in the community (Newtown health user 16: service user and member of the local community)*
>
> 1. *I am registered as a patient with a GP practice and as such I am entitled to receive consultation and treatment and/or referral for health issues. The practice (I believe) received NHS funding for having me registered as a patient.*
> 2. *As a member of the public my relationship to the NHS extends beyond that of only a patient. As a long term (unpaid) carer for my elderly mother I had extensive experience of dealing with the NHS on her behalf when she became old and frail. I have been involved in voluntary work through the Carers Project on a GP initiative project. Also as a member of the public with a vote I consider a political party's policy on NHS issues when I cast that vote. (Newtown health user 13: patient and member of the public)*

The last three of these quotations are interesting for the ways in which they combine an individual conception of patient-hood, closely based on a personalised relationship with medical practitioners, with wider collective identifications and – in some cases – active commitments.

Finally, we want to note how, in using the opportunity on the questionnaire to elaborate on their choice of words, many gave aspirational or normative responses – as in "I am currently x but would like to be thought of as y", or a particular word *should* mean something different from what it currently seems to mean in practice:

> *Fact=I am a patient – no fancy or alternative word is necessary, and I am a member of the public, but that is where it stops in terms of words.*
> *I need to be listened to; I have brains, access to the internet, know my body etc.*
> *Respected, i.e. separate wards, male/female*
> *A person*
> *I need to be trusted, i.e. that what I say is true to my best knowledge*
> *That as a patient I am part of a team and care works both ways. I have expectations as a patient – that I will get the best and most up-to-date treatment in the cleanest of environments and as a patient it is my right to have this. The word patient should be used at all times in its truest, basic meaning (Newtown health user 1: patient and member of the public)*

The formulation here of a 'truest, basic meaning' is of course a trigger for social scientists to engage in exploring how the meaning of words is constructed and contested. To explore ways in which the meaning of many of the words in question is currently being struggled for or re-negotiated we turn to an analysis of the interviews and focus groups.

Constructing the 'modern' patient

In interviews with health users it was clear that respondents perceived themselves – and wanted to perceive themselves – as patients, rather than customers or consumers.

> *I think a patient is, er, I think a patient is more or less, er, you have a personal relationship between your doctor and yourself. There is a relationship between the doctor and yourself, whereas as a customer there is no relationship. You just walk in and do your business and walk away, whereas there is a continuous relationship between your doctor and you, probably till the day you die, do you see what I mean?... [I]n my GPs surgery I'm like a stakeholder because my secrets are there, do you see what I mean? My notes are mine, my patient notes are mine, they are my problems, my illness, my concern, so again its like a partnership, that is how I see it, do you see what I mean? Whereas if I am in a shop, if I go to Marks and Spencer, I am just there to buy something, I don't have any relationship with them… No, I don't want to be a customer. I want to be a patient. I want to be a patient. I think once you become a customer you are lumped with customers in a shop, customers in a petrol station, customers in a travel insurance company, whereas as a patient you have that personal relationship which is very difficult to break* (Newtown 1).

> *I am a patient and that's the word I understand… I don't feel I'm a customer of the National Health Service, or any health service for that matter. I feel I am a patient and I would like to develop my relationship with my health care*

> *professional. Because the way I view it is, being a diabetic, and any other problem I may have health wise, I'm the one whose got it and I have to lead it. The people who are around me are my team who are helping me get there. And a healthcare professional is part of my team. But I am his patient or her patient… I think customer is a very distant relationship. I don't think it is a relationship because I can walk into a shop over the road and be a customer, but not necessarily know the person who is serving me. But I think its important that you know the person who is dealing with you as a patient* (Oldtown 3).

These quotes are interesting because the word patient is not used as a default position, but instead was perceived as an important aspect of developing and maintaining a meaningful and productive relationship with health professionals. Indeed we can see emerging constructions of the patient that incorporate or appropriate elements of professional discourses of 'stakeholder', 'partnership' and 'team' relationships, and, in the second quotation, of the patient as 'leading' the health care team. But we can also trace older inflections of the 'specialness' of the doctor-patient relationship: as the first respondent above puts it, because "my secrets are there…". These two different constructions of the doctor-patient relationship – one as more open and team-based, another as private and special, are reconciled in the idea of the doctor-patient relationship as ongoing and personal, one based on deep and intimate knowledge.

The important feature of this knowledge is not the 'expert' knowledge of the professional in contrast with the 'unknowing' patient, but a more personalised knowledge both of the self – "these are my problems, my illness, my concern…" and of the other – "I think it is important that you know the person who is dealing with you as a patient". This reciprocal knowledge is viewed as the basis on which successful relationships are based. We might tentatively ask how far this knowledge might be the basis of the 'responsible health care user' or 'expert patient' central to contemporary policy texts, and how far it might be in the process of being dismantled in contemporary reforms such as the 'modernised' appointment systems in GP surgeries and the introduction of 'choice' of hospital or treatment centre. Both, while cutting down waiting times, disrupt the continuity of care based on relationships with a particular medical practitioner. But this relational view is potentially significant for other emerging conceptions of health care – concepts of 'health literacy' and negotiated decision-making (Sihota and Lennard, 2004) are more likely to flourish if lodged in such relationships.

'It's not like shopping…'

Across both of the quotations above we can see how the normative ideal of a personalised relationship based on reciprocal ways of knowing the other is established through contrasts with the idea of being a 'customer' or of 'going shopping'.

> *I mean, for someone in my situation it is very, very important to have that rapport with the GP… I've had the carpet fitted this week and when I rang up a couple of companies to come in and quote for it they were just looking at*

> *doing a job for me, I was a customer for a particular item. Which you can't say with the doctor because it is not for one particular item, its for a very widespread number of items and so as a consequence of which it's a quite different relationship than the one where you're a customer and you are going to buy something or you want a service from them. But its generally a one off thing, you might be repeating it later, but its generally a one off thing* (Newtown 2).

Not only is the relationship more personal and is associated with a longer term investment, but the nature of the 'commodity' – health – is clearly very different from other commodities, and the nature of the transactions different from those in the marketplace.[3] This is not particularly surprising – what is interesting, here, though is the clarity and sophistication of the analysis on the part of 'lay' users, most of whom were well able to talk about the difference between health care relationships and those of the marketplace. And this analysis is rather different from that in contemporary policy documents:

This view of the patient – and the doctor-patient relationship – interrupts the attempt to construct health users as consumers. There 'patient' is understood as an 'old' term, reflecting the architecture of power and dependency; while 'consumer' reflects the transfer of power (through choice) to the user. This old/new distinction is characteristic of New Labour accounts of modernisation (as is the discussion of here of choice and equity, see also Clarke, Vidler and Smith, 2005):

> 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, 2003).

This conception of change and the implications of choice is the subject of concern to many of our respondents:

> I know 'consumer' and 'customer' imply choice and that is what we are supposed to want. I would consider it an acceptable achievement is everyone would have what was best in the matter of treatment as of right. (Newtown questionnaire 23)

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[3] Of course, the commodity analogy breaks down very quickly, since the desired object is 'health' but what is supplied – in public or private forms – is health care. This has led to a growing interest in ideas of 'co-production' around public services, recognising the role of the user as an active creator of 'ooutcomes'.

> I don't quite know what choice is about, but if it's about getting the best treatment, to give you the best chance, I don't think that should be choice, I think that should be a fait accompli. (Newtown health user 5)

Here we clearly have 'standing up' patients but they may be standing up for something rather different from that envisaged by government. [4]This is a problem for our analysis: how to make sense of the multiple relationships and identifications that people see themselves as located in. But it is also a political problem: the relationships, identifications and desires that people in our study give voice to seem to exist in angular and uncomfortable alignments with governmental analysis and policy.

Public identities and private longings?

The positive responses about public health care and the doctor-patient relationship should not be read as evidence of contentment or passivity. There was a consistently strong desire for better health care. Some respondents appreciated the kinds of facilities that they had experienced in contacts with the private sector.

> *I've been to private doctors, and my private doctor, the way they treated you and the way my current doctor treats, is time. They sit with you, they understand you, whereas they talk to you a lot more and they give you a lot more options. They spend more time with you, its just time. Whereas an NHS doctor wants to get out and get the next patient in as quickly as possible… If I am in the private sector, if I am in PPP or whatever, if I'm sick they say well come in now, whereas if I phone my GP they give me a date. If you are ill and you have PPP they book you in the next day, whereas here you have to be on the waiting list. If you go into a PPP hospital, when I worked in the private sector we used to have PPP, and you walk into a hospital and you think oh my god, it's a bloody hotel. It is beautiful, it is neat, the doctors treat you with courtesy, the nurses treat you with courtesy, you don't sit around reading 1945 Home and Country, or whatever magazine. You know you are treated just like that. The services might not be better. It might be the same doctor that is treating you in the NHS that is treating you privately but again it is just the environment, the courteousness, the response you get. You say can I have a glass of water, they get you a glass of cold water. They treat you nicely. You don't get that on the NHS but again that is probably not the NHS's fault because they have a lot to deal with* (Newtown 1)

> *Yeah, the fabulous thing about private, I suppose, the doctor has a long time, or however much time you need to talk to you about your problem. I've found that they discuss, they are more willing to discuss what the problem is, and to consider various options. And I've also found they are much more willing to*

[4] Choice continues to be a focus of contradictory or ambivalent reactions in our study like others. Choice is valued abstractly, as a positive condition or as a possible means to service improvement. But there is substantial anxiety about its potential effects in producing (or reproducing) inequality; about its practical implications (e.g., travel to distant hospitals); and about whether there are better choices than choice – other surveys suggest that the choice between individual choice and investment in local services evokes preferences for the latter. A recent study by the Work Foundation found that while people valued choice in public services, they were unable to work out what choice actually meant (Ref to come). Given the indeterminacy of choice in political and policy discourses, this seems hardly surprising (Clarke, 2005a).

> *answer questions. I have found that a lot better… Saxon Clinic is of course very clean. I have been there as a day patient and the room was - the bathroom was absolutely immaculate, you don't have to take your own cleaning stuff and that sort of thing… You may not get any better treatment, I'm sure you don't, because you know the NHS standards of treatment are absolutely excellent, but… its not stressful in any shape or form* (Newtown 6).

Here there is a sense of longing for the kinds of facilities available in private hospitals, and for the time and attention received from medical practitioners in the private sector. These factors are at least as strong – if not stronger – than the waiting list issue around which the 'choice' agenda has been constructed. Time and attention in the consultation process were the most critical factor, but then it seemed to be the little things that stuck in people's memories and that symbolised the virtues of private treatment – the 'immaculate bathroom', the 'cold glass of water', being treated 'with courtesy', not having to 'sit around reading 1945 Home and Country', and so on.

But despite these sentiments, even among respondents who regularly used the private sector there was a strong public identification with the NHS. This is present in the final comments at the end of each of the quotations above: the idea that it's not the NHS's fault that such longings cannot be realised "because they have a lot to deal with', or that such longings are only superficial because "you know the NHS's standards of treatment are excellent". This latter idea came through strongly in the focus groups we held in each town:

> *The private sector can deliver a television in a room and decent meals, maybe. I don't believe it delivers better health services. A consultant or a surgeon who is doing operations at the end of an NHS day and rushing into the Saxon Clinic to do hip operations at 10 o clock at night is not giving the same service as he is during the day. You can hear horror stories about private health much more than you can about the NHS* (Newtown Focus Group).

> *[T]hey don't have the same medical cover in a private hospital. If anything goes wrong, where do they have to go? They have to come back into the NHS for A&E or intensive care. You know, its all very nice if you have got something mild wrong with you and you go in and you have a nice environment and everything else. But if you want to have doctors who know what they are doing, have someone on call twenty four hours a day. People have the wrong perspective about private hospitals. Who do you think provides medical care in private hospital? It is the NHS doctors… people have got to wake up to the idea that they do not get better clinical care in a private hospital… People would be horrified at the lack of clinical care in a private hospital - the drug errors etc that go on in a private hospital. They would be horrified* (Oldtown Focus Group).

And we found a deep attachment to the *idea* of the NHS and an antipathy to more privatised health model which would produce greater inequalities:

> J: *I do think it really matters who provides the service because if we are going to have a society where people have equal access, it can't happen while we*

have this stupid thing about it doesn't matter who delivers the service. It is absolutely essential that the public service can provide the best quality service, across…

S: *In the end the private sector has to make money, that is what they are there for. And the NHS doesn't. And that is why I am uneasy. And I am uneasy that they are pushing us towards an American model where you will either be in and OK or out and very poor and get the basics, with a huge swathe in the middle. And if you've got a condition that knocks you out of health insurance - I just don't want to go the American way* (Newtown Focus Group).

This sense of the importance of the publicness of health, evident in the numbers of respondents who ticked 'member of the public' or 'member of the community' in the questionnaires (see above) – seems to transcend problems arising in people's actual experience of using the health care system.

In search of a conclusion:

There are clearly some programmatic statements that we might make by way of a conclusion. The idea that this process of reform or transformation of public services is about the shift from citizens to consumers fails to touch the relationships and identifications expressed by people in our study. These are not the primary categories through which they live, and think about, their connections to public services. Nor does the consumerist model describe who they – nor who they want to be.

At the same time, their orientations cannot be understood in terms of satisfaction with an old model of dependency or passivity. They are assertive (both bout their own experience and the system as a whole); some operate as 'experts of their own condition'; they understand the 'inter-dependency' of their relationship to public services; and they have both desires for improvement and views about what such improvement might look like and how it might – and might not – be achieved.

Equally, we would want to argue that these orientations are not merely residual (Clarke, 2005b). The New Labour binary of Old and New is a residualising discourse, attempting to consign contrary orientations to history, while claiming the one best way to modernity for themselves (Clarke and Newman, 2004). We see no reason to think that the people in our study – and their orientations – are in practice residual (though they certainly know that other futures are being planned and implemented). The resilience of their conceptions of publicness, membership, and collaboration seem to us to be both a resource and a problem for New Labour's approach. The assertiveness of such health users (their willingness to 'stand up') is constantly glossed by New Labour as 'consumerist'. But the desires and anxieties about both the present state of the NHS and its imagined futures suggest a failure to install a consumerist subjectivity.

But these are the easy conclusions. We think there are many other issues raised by our study with which we are only just beginning to come to terms. Terms is, of course, a key word … we are unsure about how to make sense of the identifications discussed here and the relationships that they are seen to embody (in complex and contested

ways). 'What's in a name' turns out to be a lot. We think these are identifications, rather than identities: they are about imagined or desired forms of attachment and belonging to domains, institutions, practices and people. Each term – each name – is itself the subject of different inflections and interpretations: the patient is not a singular mode of being. We suspect that these terms voice desires and anxieties – as well as making sense of experiences. These desires and anxieties, we suspect, are ill-represented in public discourse and, at the same time, are shaped by public discourse (at least, for many of our respondents, public discourse made them more anxious and angry).

At the same time, these identifications are multiple and mobile – carrying deep commitments and being contingently deployed. We have been struck by the capacity of people to engage in complex forms of what we have called elsewhere 'relational reasoning' about public services (Clarke, 2005c). This reasoning about relationships with public services may be a sampling effect – we got to talk to the people who want to talk about public services – but we see no other reason to think that it is uncommon. It suggests that categorisation of people's relationship to, and view of, public services (citizen-consumer; active-passive; patient-expert patient) may miss the multiplicity and mobility with which people understand these relationships. The implications for policy and practice are significant; so are the potential consequences for politics. In the meantime, social scientists might need a better analytics for thinking about the dynamic relationships between publics and public services than the citizen-consumer binary.

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