

# New labour and reform of the English NHS: user views and attitudes

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## Abstract

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**Background** The British National Health Service has undergone significant restructuring in recent years. In England this has taken a distinctive direction where the New Labour Government has embraced and intensified the influence of market principles towards its vision of a ‘modernized’ NHS. This has entailed the introduction of competition and incentives for providers of NHS care and the expansion of choice for patients.

**Objectives** To explore how users of the NHS perceive and respond to the market reforms being implemented within the NHS. In addition, to examine the normative values held by NHS users in relation to welfare provision in the UK.

**Design and setting** Qualitative interviews using a quota sample of 48 recent NHS users in South East England recruited from three local health economies.

**Results** Some NHS users are exhibiting an ambivalent or anxious response to aspects of market reform such as patient choice, the use of targets and markets and the increasing presence of the private sector within the state healthcare sector. This has resulted in a sense that current reforms, are distracting or preventing NHS staff from delivering quality of care and fail to embody the relationships of care that are felt to sustain the NHS as a progressive public institution.

**Conclusion** The best way of delivering such values for patients is perceived to involve empowering frontline staffs who are deemed to embody the same values as service users, thus problematizing the current assumptions of reform frameworks that market-style incentives will necessarily gain public consent and support.

## Introduction

Since its inception, the NHS has represented a problematic for UK political and policy debates – an imperfect compromise worthy of celebration whilst being a perpetual object of reform. The most recent incarnation of this tension has seen

both major UK political parties more or less committed to a traditional NHS ethos of tax-funded, universal healthcare free at the point of use, whilst subscribing to a critique of this model, believing it no longer meets the needs or the expectations of a more discerning and scrutinizing consumer-public.<sup>1</sup> It is this alleged gap

in performance and legitimacy that the New Labour government's programme of 'modernization' is designed to address – a combination of increased levels of financial investment with an agenda for the reform of NHS practices and structures fashioned round the needs and experiences of patients.<sup>2</sup> As well as the formalizing and expanding of patient choice, there has been the introduction of competition between healthcare providers from public and private sectors, a system of incentives that will drive the market and a commitment to challenge information asymmetries through the publishing of performance ratings. This paper will begin by briefly mapping these key facets of the reform agenda and examining the rationale for their implementation. It will then move onto describe the research findings from a recently conducted qualitative research project in the South of England into public responses to the market reform agenda. Finally, the paper will discuss the pertinent findings and explore some of the responses.

## Background

Over the last two decades, the infiltration of New Public Management approaches<sup>3,4</sup> within healthcare has come to represent orthodoxy for both Conservative and Labour administrations as a way of managing the pressure applied to welfare states by tight fiscal parameters and changes in demographic structures.<sup>5</sup> In addition, the creation of quasi-markets within welfare systems have also been considered a crucial tool in dismantling self-serving public bureaucracies and shifting power away from 'producer' interests into the hands of 'consumers' of welfare services.<sup>6</sup> Presently, market-style reforms continue to have a place in the ongoing 'modernization' of the NHS, conceived as they are by Government as an effective way of innovating services, expanding capacity and improving efficiency and accountability to patients.<sup>7</sup> This has resulted in a programme of restructuring through increased competition between service providers, the expansion of patient choice and performance management regimes based around targets and financial incentives.

A key aspect of the NHS quasi-market is the splitting up of purchasers and providers within the service governed by a financial framework of 'payment by results'.<sup>7</sup> This is a break from previous systems where funding flowed from purchasers to providers on the basis of block contracts. 'Payment by results' on the other hand, backed up by a national pricing tariff for all health procedures is designed to 'offer [providers] the right incentives to reward good performance, to support sustainable reductions in waiting times for patients and to make the best use of available capacity'.<sup>7</sup>

The 'payment by results' framework is now an integral feature of another distinctive facet of the market reform of the NHS: patient choice. The process of 'empowering' patients as discerning consumers of healthcare has been matched with financial mechanisms to ensure money 'follows the patient' to bolster their 'purchasing' power. Health providers are incentivized to offer services of quality and efficiency that will attract patients (and become more profitable) whilst the commissioning authorities must finance the care pathways chosen by patients. According to the Department of Health, patient choice (combined with payment by results) is the best way of ensuring that providers are responsive to the needs of patients.<sup>8</sup> Accordingly, between 2006 and 2008, patients needing planned (elective) care were offered a choice of four or five options of where to have their treatment.<sup>8</sup> This has since been expanded so patients are now theoretically able to choose any provider for their treatment who can meet NHS standards and costs. These options may include an array of state or independent sector providers.

A further important feature of the NHS quasi-market is a stringent targeting and auditing regime whereby performance standards are set and measured by regulators and patients. This is seen as critical in addressing the 'information asymmetries' that have been identified in healthcare markets.<sup>9</sup> Hence, during New Labour's early years in power, a framework of governance, labelled '*targets and terror*'<sup>10</sup> emerged in the NHS. This target regime was enshrined in the *NHS Plan* (2000) which

announced the introduction of performance targets to be met every 3 years by PCTs. However, the initial figure of 62 national targets was reduced to 20 in 2004 to provide PCTs with some scope to decide their own priorities within each locale.<sup>11</sup> Since the NHS Plan, there has been some recognition therefore that effective markets require a balancing of incentives to improve performance alongside external indicators against which market actors can assess that performance. This may also have reflected concerns raised about the effectiveness of external targets in improving health outcomes and their effect on professional autonomy and motivation.<sup>12</sup>

### The study – aims and method

The aim of our study was to explore NHS user views and perceptions of market reforms of the NHS and how these reforms related to their own normative judgements about healthcare and welfare provision. Our research was an independent academic study funded by the Economic and Social Research Council and was a qualitative study of 48 'lay' individuals in the South East of England. Forty-six of the participants recruited had been users of NHS services in the previous 12 months. Using a quota sampling strategy, we divided our 48 participants between three localities – a metropolitan area, a provincial town and a village. We felt it important to have a significant but feasible sample size that would also enable us to divide evenly across three sites. We also had quota domains taking account of gender, socio-economic status and age (used as a proxy for levels of caring responsibility). Each interview followed a semi-structured schedule, was recorded and lasted between 40 and 90 min. Respondents were informed about the project they were participating in and how their comments would be anonymized but could be used in published research papers. Each was paid £25 for their participation and time. In terms of the findings of the research, we are of course aware that these may reflect a sampling bias deriving mainly from the geographical location of the research and that it is possible that another

location may have generated a different set of responses. We are also mindful of the influence of the constant hum of media coverage of the NHS, which may have influenced the concerns of our participants. However, we aimed where possible to ground discussions in the values held and feelings experienced by participants in response to current reforms, rather than pervasive media narratives. In terms of interview content, we began each interview with a general enquiry about levels of knowledge and understanding of the reform agenda. We also asked about a general sense of what the NHS represented or 'meant' to participants. Interviews then proceeded by examining a range of themes including how the NHS should be funded, levels of satisfaction with the service and the bases of trust in the NHS as a set of institutional and relational practices. These discussions included probing on experiences and feelings about recent reforms such as competition, choice and the use of targets and incentives. In each case, brief details were provided about the direction of reform, but participants were not asked explicitly about, for example, the role of matrons vs. that of hospital managers. The resulting data was coded through Nvivo and seven overarching themes were identified to inform the analysis. The goal of the analysis was to explore the bases and status of public trust in the NHS and to examine what impact the dynamics of market reform is having or is likely to have on public trust. The data in this paper draws on one of those themes - responses to market reform - but clearly overlaps with other thematic areas including trust and experiences of patient care.

### Findings

#### Performance targets and incentives

The principle of incentives for staff was lauded by some respondents who believed public sector staff should not be exempt from a culture of performance management that is seen as the norm in other work arenas. However, this was matched by unease about the practical effects of targets:

If you use financial indicators then surely they will be tempted to cut corners...the state sector needs targets, but they shouldn't be asked to perform as a business when they are not a business they go out there to provide care and look after people.

(Larry/Family/E/City)

Others were less equivocal:

It [the NHS] is getting worse purely because they are getting made to focus on targets which is a wonderful way of manipulating results for the government: 'look what we have done with the NHS', they may well have improved the figures, but the figures have had to be jiggled around by the staff to make it appear as though waiting lists are down and that sort of thing.

(Brackets added; Sally/Post-family/E/Town)

This latter sentiment was a recurring one in many interviews where targets were often viewed as part of a short-sighted attempt to create an image of an efficient NHS by pressurizing staff into quicker diagnosis and faster throughput of patients. Few, if any respondents were aware in the reduction in some waiting times that targets may have helped engender in recent years. Therefore, the possible benefits of targets were largely ignored for a focus on how centrally imposed targets could undermine the ability of medical staff to deliver adequate patient care:

Obviously they have these government driven stats that they have to adhere to as well, which maybe stops them giving patient driven care. You know if they have to make these targets or they don't get any funding...then maybe they lose sight of what is important.

(Shilpa/Family/B/Town)

Too many chiefs?

The critique of targets was frequently connected with negativity towards what were variously described as 'pen pushers', 'bean counters', administrators and bureaucrats within the NHS. This was either because their employment was seen as diverting resources away from frontline care, or because they are the embodiment of the 'red tape' and number crunching that comes with targets and general budgetary management and

undermines the 'real' work of care. Therefore, whilst the guiding logic of market reforms has been to replace the 'old-style' bureaucratized NHS monolith with a more flexible, responsive service, our respondents largely felt such reforms have not swept away the 'dead hand' of state bureaucracy, but in fact created new opportunities for unresponsive provision bogged down in the management and administration of the NHS market than patient care. This finding echoes recent survey data showing the second biggest concern the public have about the NHS (after funding shortfalls) relates to a perception that money is wasted on excessive bureaucracy.<sup>13</sup> This also echoes the findings of Dolan, Cookson and Ferguson (1999), although they suggest that attitudes to managers may soften over time once the complexity of decision-making has been reflected upon.<sup>14</sup> This in turn invites us to question whether initial reactions to 'bureaucracy' are rather knee-jerk emotional responses reflecting the negative connotations tied to management and administrative practice generally. Nonetheless, in our study, there was a division made between what is seen as the legitimate work of the clinical staff – usually expressed through notions of 'proper' nursing and 'caring' – and the illegitimate, wasteful and corrosive activities of over-bearing management and administration:

I think the actual healthcare professionals go in it because they want to help people. I think they are on the side of the patients... non-health professionals in the health system are perhaps more interested in PR and finance and how they look and are they meeting targets etc. and, I suppose they are more removed from it.

(Alice/Post-family/C1/Village)

The perception that the NHS is overburdened with bureaucrats appears to clash with a sense from respondents that something has been 'lost' from the NHS that it has been commercialized and is controlled by individuals who are too far removed from patient experience. This may have illustrated the mobilization of a 'nostalgic discourse'<sup>15</sup> by respondents in response to feelings of anxiety about reform, but

it also seemed to reflect an adherence to a particular value framework about what constitutes appropriate healthcare practice that is in tension with the priorities of the NHS currently:

It is too money orientated. It feels like there is no humanity left in the NHS, you know, there is no human compassion, it is just you are a piece of meat or a pound sign, or a number or all of those things, that is what you are treated as...I dunno when it started, all I know is it is getting worse and something needs to be done.

(Nina/Pre-family/D/City)

When respondents problematized the NHS, they often constructed frontline medical staff as adhering to a similar normative value frame, but as being victims of an imposed culture of targets and parsimonious budgetary management. Indeed, on the whole, doctors and more particularly, nurses were viewed as being well-intentioned ‘knights’<sup>6</sup> with the appropriate normative values of care, respect and professional conduct who have to work in difficult conditions:

Staff are just doing their job, although there is maybe not enough money or too much pressure so they can't do their job properly. Their personal values might not mean a thing because there is not enough facilities for them to do their job properly.

(Mike/Pre-family/C1/Town).

Thus, the re-orientation of the NHS back towards the normative framework held by many respondents and perceived to be shared by frontline staff demands an increase in power and influence for frontline staff that will enable them to challenge or override the non-clinical priorities of management bureaucrats. For a number of respondents a clear solution presented itself:

One major problem is when they took matrons out of wards suddenly things seemed to deteriorate and I think now there are more chiefs than there are Indians...they [patients] are just left, they are not looked after at all properly. I just say bring back the matrons...They just had a finger on the pulse. I mean who does now, an administrator in an office somewhere?

(Pauline/Post-family/C2/City)

The ‘return of the matron’ was a powerful narrative for many respondents. It furnished their

belief in a normative framework for healthcare practice that prioritizes ethics of care and respect dispensed by empowered professionals. The iconic matron is seen as embodying these values – values which are closely aligned with those of patients. Therefore, the matron was also a defensive construction – someone who could protect the needs and values of patients against the damaging influence of management:

You don't need targets if you get a matron in. You really don't. That is who I trust...I would have a really informed panel deciding who was going to be the matron and the matron would be in touch with the top and the top would listen.

(Mabel/Post-family/C1/Town)

### Competition and private sector involvement

The ‘bring back matron’ narrative that seemed to resonate with so many respondents often crystallized around the issue of so-called ‘superbugs’ such as MRSA and *Clostridium Difficile* (C.Diff) within hospitals. Understandably, for many respondents this was identified as a huge current problem for the NHS – particularly given the problems of a local NHS trust which had gained wide media coverage. Nonetheless, discussion of ‘superbugs’ tended to tap into the matron narrative in that infections were seen as symptomatic of the absence of caring, but authoritative figures who would protect patients through the strict maintenance of cleanliness standards. However, there were alternative (though related) explanations offered by respondents. For example, for some the root of the problem was the outsourcing of cleaning to private contractors:

There are serious problems with outsourcing. If you contract out cleaning, then they will pay the cheapest wage and deliver the least good service. It is a false economy....

(Tim/Pre-family/C1/City)

However, the issue of outsourcing cleaning services was not seen solely as an issue of standards. The more subtle allusion was that contractors were viewed as not operating with the same normative framework as patients

and medical staff. As with bureaucrats, they were deemed to be strangers to these values – outsiders who do not understand the social relations inherent in patient care:

[I am] not happy with all this piecemeal contract stuff because you haven't got the common identity, you are not all part of that working community. It's like the cleaners - they are not part of the hospital, they are brought in. Although it doesn't mean you can't bring expertise in, but I think they need to be part of that whole unit so there is an identity there.

(Sheena/Post-family/C1/Town)

Perceptions about the involvement of the private sector within the NHS as a whole were often suspicious. However, when it came to management (that is, non-care arenas) of hospitals and trusts, some were pragmatic about what it could bring to the NHS. Of our 48, 14 of our respondents believed it to be a positive step, arguing that the NHS should be more business-oriented and that 'the ends justify the means':

It might be able to run a hospital better. Everything boils down to money and maybe they can see where money is being wasted through bad management.

(Pauline/C2/Post-Family/City).

This comment operationalizes a contrast that is often drawn between the public and private sectors and their respective ability to be efficient and responsive to patients. Indeed, recent survey evidence has illustrated how the public perceive the private sector to offer better managed, more pleasant and safer (less infections) healthcare provision than the NHS.<sup>13</sup> However, despite this our research found that despite identifying both a lack of capacity and inefficient hospitals as a problem, there was concern expressed by respondents about whether greater private sector involvement in the NHS would be a net benefit. For example:

It just sounds scary to me it really does. I think because of the track record of when that has happened you know with railways...it is so bitty. I wish I had more knowledge of it but that is my instant reaction.

(Mabel/Post-family/C1/Town).

A further 19 respondents said they were against this aspect of reform, with several voicing objections on the grounds that it would move the NHS further away from its traditional model:

I find that totally amazing that it has come from a Labour government. It is just ludicrous. They either have a private health service or a national health service...they are trying to make them mix...I don't think it is right. I think it is the National Health Service and they have got to get it right. They ain't getting it right at the moment.

(Rod/Post-family/B/Town)

A number of respondents spoke of private sector involvement in this way, unclear what it would mean for the 'traditional' NHS principles of equity, universalism and free at the point of use. This was often the source of the ambivalence demonstrated by those nominally pro-private involvement:

Again if it raises the game of the hospitals and the facilities and conditions improve then I think it would be worthwhile, but again...I think because it is a free facility for everybody, people start getting worried that it will all sort of change and we will have to pay costs for certain facilities and certain treatments.

(Donna/Family/C2/Town)

Another key feature of market reform to arouse strong feelings was the increased competition between healthcare providers. We found that seven of our 48 respondents were enthusiastic about competition amongst providers. However, many respondents (26 in total) were less enthusiastic about competitive mechanisms. As with private involvement, some had a principled objection to competition within the healthcare arena, arguing that it contradicted the 'universalism' of the NHS:

I just really don't feel the NHS is something that should be privatized or should be run in that way. You should choose your doctors surgery near where you live and know that it's going to give you the exact same service as any other in the country...

(Jackie/C1/Pre-family/City)

Others pointed to the possibly damaging implications of competition:

Why split it out and make everyone compete with each other? That is the problem with the NHS, everyone is competing and trying to win more money. They start doing specialisms too 'oh we do this special thing' and it takes the money away from someone else because they get more funding. The problem is that when people find quicker, better ways of doing things they are not going to be sharing it all out to the big wide NHS community anymore because they are going to be thinking, 'wait a second we have to keep it to ourselves because we get more funding this way'. That's what I think the problem is.

(Andrew/Pre-family/C1/City)

Objections to competition were often bound up with the sense, outlined above, that the NHS is being reformed in a direction that increasingly fails to enshrine values of patient care and public service. There was no perception that the introduction of competitive mechanisms would enhance the quality of care for patients. Indeed, the opposite was the case – that respondents believed competition to be a further distraction for clinical staff and was about exploiting patients as generators of profit rather than exhibiting particular needs to be met. The following quote from Eleanor is a good illustration of the disempowerment that seemed to be felt by many respondents who, rather than thinking about how best to exploit markets in welfare services, feel alienated by a lack of ownership or resistance to reform:

I have seen all this go on with schools...exactly the same thing... and this is about people's health and their lives and their relatives and their children and their parents and it shouldn't be a competition it should just be done, they should be sorted. I think it is appalling that they do that actually. It is not the way it is going to run at all. It is not a competition, they are not businesses, they are hospitals with doctors and nurses and it is about people's emotions, it is not a business.

(Eleanor/C2/Family/Village)

Therefore, as with the responses to 'bureaucracy', despite the logic of market competition being to enhance the responsiveness of the NHS to the needs and choices of patients, there is some evidence here that patients feel that market

mechanisms actually undermine their ability to trust and support the service. There was a sense from some respondents that the provision of 'choice' missed the point somewhat:

It is perhaps giving something to people that they don't really need or want...I don't know that people want that market choice. Yeah, you might want a choice of where you buy your milk...but it is such a basic requirement to be healthy...that it is not something that you really need.

(Luke/E/Family/City)

This raises doubts about the way in which patients are being 'empowered' within a market system and whether an expansion in patient freedom actually compounds a sense of disengagement in which the patient often feels like a participant in a system that is designed and administered *elsewhere* rather than being a meaningful stakeholder.

### Making choices

The corollary of competition – patient choice – also polarized opinions of respondents. Of the 48, nine expressed unqualified support for choice. Often this was because they had had negative experiences of local hospitals that they understandably wanted to avoid:

One should always have a choice. Eventually word gets around that if people have been to two places then one is good and one is bad, but if you have no choice and you always go to the same place you have no comparison.

(Rupert/Post-family/D/Town)

Fourteen respondents expressed outright hostility to choice, some stressing their concern about the necessity of making a choice and their belief that choice may introduce inequality of healthcare provision:

It should be consistent service wherever you go. For example, if you go into a Gap store, you know, customer service is generally speaking fairly good, it is all consistent. You go to a Gap store here, in London, or one in Brighton, it is all the same and that should be the same with hospitals, there should be consistency wherever you go.

(Eric/Pre-family/C2/Town)

There were some respondents who were resistant to the individualized consumer model from which the patient choice agenda derives. This may have been because they believed in universal standards of care (like Eric above), or because they were unsure how to handle the choice-making process:

People just want to get better quickly. She would just want good, quick treatment, we don't care where. How do we make an informed choice? Hospitals have varying outcomes, so how can you judge? It is a false choice though because people are not informed enough.

(Cherie/Post-family/C1/City)

Indeed, a majority of 25 were unsure whether they wanted, or how they would handle choice. This reflects findings from recent survey data that showed choice (of hospital and admission date) ranks very low in importance for patients.<sup>16,17</sup> This trend could reflect a similar finding in our study where individuals were dubious about the reality and practicalities of choice rather than the principle *per se*:

Patient choice is ridiculous. What good is choice going to make for me? When I am ill I just want to get into a hospital and be tended to by people who know what they are doing. It is ridiculous. Who am I to choose I want to go to this hospital or that hospital? I don't know where the empty beds are, I don't know who is under staffed or over staffed or less stressed... I would go on what the doctor recommended.

(Susan/Post-family/E/Town)

Perhaps this perception is unsurprising in light of two pieces of recent Healthcare Commission research which show how uneven the provision of choice can be. They found in each respective study only 26 and 27% of individuals they interviewed in primary care had even been offered choice of hospital.<sup>17,18</sup> This was reflected in our study where only two respondents stated they had ever been offered a choice of provider. In terms of how people would exercise choice (an almost wholly hypothetical question at the time of interview given the limited experience of choice people had), eight respondents stressed the importance of a local hospital or clinic. This local dimension to

people's choice-making offers an interesting perspective on the choice agenda. Recent survey data has shown that patients are more likely to prefer to pay more taxes for a good quality *local* service than pay nothing extra and have unlimited choice across the country.<sup>13</sup> In addition to these eight respondents, a further 11 out of 48 people said they would make use of official ratings and other Government statistics to make comparisons, although most were unfamiliar with such information reflecting findings elsewhere.<sup>19</sup> Other respondents were more distrustful of government information and 11 stated they rely on personal networks encompassing friends or family before choosing, whilst seven said they would rely on their GP. This group viewed GPs as an expert resource that would enhance the choice-making process – reflecting findings elsewhere showing the importance of GPs as choice 'advisors'.<sup>20</sup>

## Discussion

There are a number of points we can draw from these qualitative findings. First, the respondents in our study were generally supportive of values associated with what we might call the 'traditional' NHS model – a universal service, free at the point of use underpinned by a strong ethos of patient care. There was also little support for the NHS to be dismantled, despite a sense that it is faced with an unprecedented range of pressures and problems and is under-performing in key areas. Indeed, most are supportive of 'frontline' medical staff and attribute this under-performance to under-funding or misspending of resources and an over-bearing bureaucracy. There is a commitment on the part of most respondents to a particular normative framework which constructs the social relations between patient and clinician as founded on values of care and respect. This is a dynamic of healthcare practice and alignment of values that is seen as underpinning the 'humanity' of the NHS and trust in health professionals. By contrast, there is an impression that the NHS as an organization is not as focused on delivering healthcare as it once was, is too preoccupied with budgetary concerns as well as administrative minutiae and

has been infiltrated by individuals whose actions do not understand or support the social relations of care deemed to be a key feature of the NHS. This is clearly a paradoxical set of responses in which any benefits deriving from market reforms and rigorous performance management have not registered with the public, or are not valued to the same degree. The call for the return of matrons can be seen to reflect unease at this perceived shift in priorities and is identified as a way of reasserting care related principles whilst offering patients protection from the amoral rationalism of NHS bureaucracy. The perception that the matron is more aligned with patients' interests than NHS managers challenges a key assumption of market reform logic – that the needs of patients are best met through incentivizing hospitals to meet certain financial and administrative targets and suggests that the respondents in our sample at least are expressing a sense of disconnection from the NHS. Consequently, they are supportive of any means by which 'their' needs and values will be embodied within the service. With the introduction of 'modern matrons' we could argue New Labour responded to public anxiety about the need for a defence of principles of care within the NHS. This has been interpreted as an example of how policy can attempt to engage and harness the nostalgia of patients and NHS staff for a bygone era and illustrates the contradictions that lie at the heart of the healthcare 'modernization' agenda.<sup>15</sup> Similarly, choice policy within healthcare has been interpreted as an attempt to express an idealized model of consumption designed to ward off the psychological angst generated by the realization that there are inherent vulnerabilities and risks in life that are beyond the reach of policymakers.<sup>21</sup> In light of this, it is perhaps important not to construct current health policy as imposed from on-high without regard to the feelings and needs of patients, but rather as complex terrain fraught with tensions. The question of course is how authentic such responses are and whether patients feel they are genuine attempts to understand and reflect their concerns. Certainly, none of our respondents mentioned or felt that current reforms were trying to reflect the concerns of patients, which, even if misplaced or

contradictory, has implications for public support and engagement in healthcare reform. Therefore, it would appear that there is a need to take far greater cognizance of the quality of the patient care experience and improve understandings how patients conceptualize that experience – not just through rational calculus, but within and through normative value frames that prioritize affective and emotional resources of care, respect and fairness. We argue that whilst nostalgia may play a part in framing responses to recent reforms, this often derives from a sense that normative, expressive values are being compromised within healthcare reform – values which are argued to be intrinsic to continued public support for and trust in progressive welfare institutions.<sup>22</sup> As such, the sense of unease expressed about the current condition of the NHS appeared to be rooted in negative perceptions of quasi-market reforms. This supports recent survey evidence showing little appetite amongst the public for a re-structuring of the NHS.<sup>12</sup> In our study, respondents largely considered these reforms to be a distraction from, or exacerbating the 'real' problems of the NHS and cementing the move away from principles of care:

Innovations just seem to be vote grabbing rather than caring about the community...Maybe they should go back to the original concepts...More healthcare rather than targets and business plans...

(Donnie/Post-family/C1/Village)

There seemed to be a feeling that given the normative values through which many people constructed the NHS, market reforms are not a good enough solution to its current problems, although of course we should bare in mind that the reforms under discussion here have not been in place very long and may attract greater support over time. Nonetheless, many respondents feel a deep uncertainty about their role within the new quasi-market settlement. There are important questions raised here, not just about market logic, but about the redefinition of welfare citizenship in a supposedly more 'responsive' epoch. How much empowerment and sense of ownership do citizens feel they have over the reform process when such an agenda persists in the face of what is, at best,

ambivalent public support? This reminds us that a reform agenda that appears to exclude or contradict the views and values of users of services risks losing the support of those on whom its legitimacy depends. This could have damaging repercussions for collectively provided welfare institutions in the future and invites us to question the capacity of the 'ethical' health consumer to exercise 'responsible' choices within a system that induces such unease.<sup>23</sup>

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## Conflict of interest

None.

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