

The Complexities of 'Consumerism': Choice, Collectivism and Participation within Britain's National Health Service, c.1961–c.1979

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Summary. This article explores the overlapping and conflicting points of contact between 'consumerism', collectivism and participation in Britain's National Health Service during a period of relatively well-funded expansion during the economic 'golden age' of the 1960s and 1970s. Despite recent neo-liberal attempts to define 'consumerism' around the wishes and choices of the individual, and to conceptualise areas such as individual hospital referrals as particularly 'consumerist', this article demonstrates that collective provision, the protection of disadvantaged groups and the concept of 'participatory' citizen involvement were all alternative meanings of the concept during this period, co-existing uneasily with the competitive concepts that have become more familiar since the late 1980s. This insight is then utilised to show how health care debates today might become better informed, ignoring extreme claims for all three concepts and focusing instead on a theoretically informed but ultimately empirical grasp of constant flux in any health care system.

Keywords: patients; consumerism; collectivism; participation; rights

The concept of 'consumer choice' within the British health care sector has long been theorised as involving more *individual* 'choice', a notion associated with the Stanford economist Alain Enthoven and promoted by the Institute of Economic Affairs and other neo-liberal think tanks.¹ Enthoven was the original populariser of an 'internal market', in which a plurality of healthcare providers is paid to provide each medical service, and he turned the previous history of British healthcare diversity to the advantage of his own arguments.² Reforms initiated during Mrs Thatcher's last years in power, continued in attenuated form under John Major, were the most powerful expression of this idea right up to the present Coalition government's proposed reforms in 2010–12.³

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¹A good summary of these views can be found in A. Seldon, 'The Economic Fundamentals', in G. Murley (ed.), *Patients or Customers: Are the NHS Reforms Working?* (London: IEA, 1995), 55–67.

²A. C. Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* (Amsterdam: North Holland Press, 1988), esp. 8–10.

³A. Mold, 'Making the Patient-Consumer in Margaret Thatcher's Britain', *Historical Journal*, 2011, 54, 2, 525–8. T. Milewa, J. Valentine and M. Calnan, 'Community Participation and Citizenship in British Health Care Planning: Narratives of Power and Involvement in the Changing Welfare State', *Sociology of Health and Illness*, 1999, 21, 4, 450–6.

It is, however, the intention of this article to follow and analyse the very different and indeed social-democratic meanings of such terms during the brief 'golden age' of generous funding and reorganisation that stretched roughly from the publication of early consumer studies in 1961 and 1963 to the election of the first Thatcher Government in 1979. By so doing, it will explore the many meanings of health 'consumerism' in the NHS during the 1960s and 1970s. Such discourses were multifarious, and certainly not analogous to the meaning of the word in the early twenty-first century. This article will examine policy responses during a period when the reaction of both citizenry and officials was not to emphasise individual rights, but group participation in the sense of joint and constant control over service provision.⁴ It will track such reactions under three headings: the increasing *collective* surveillance of governance failings in state-led medicine practiced within public bodies ultimately subject to election or to oversight by politicians; the perceived need to reform practice *overall*, so as to avoid scandals and controversies that appeared inherent to the system; and popular calls for 'participation', embodied in the creation of Community Health Councils (CHCs), as another and again overtly *social* variant of consumer ideas in the policy-making arena. All of these were ways of instilling 'voice' among citizen-consumers, and encouraging 'loyalty', rather than putative 'exit', in the political scientist Albert Hirschman's influential typology.⁵

It is entirely understandable that contrary and individualistic variants of the concept of 'consumerism'—the 'exits' characteristic of competitive business enterprises—have dominated the literature. Recent enthusiasts for 'choice', such as the healthcare economist Julian Le Grand, have made ambitious claims for the efficacy of health care individualism and personal choices made between one service and another. Since very few hospital admissions are emergencies, they argue, patients will use fruitfully the time they have to assemble and think about a wide range of choice—between doctors, hospitals and treatments. Le Grand has continuously advocated the provision of guided choice, albeit limited by fixed costs to prevent 'cream skimming' and cost cutting.⁶ The choice agenda, as Le Grand points out, at least has the virtue of public support as recorded in opinion polls asking voters whether they want a choice of hospital or consultant.⁷ Gordon Brown as Prime Minister also, and predictably given such polling, explicitly linked the ability of the NHS to embrace 'patient power ... [with] more choice for patients ...', with the 'increasing freedom to make individual choices as consumers we rightly take for granted'.⁸

Such discussions are too ideologically motivated, and too temporally specific, to be of much help to the health care historian. Although the focus on patients' options and selections is understandable given levels of political controversy over health care in the early twenty-first century, the historical record can be distorted by prevalent discourses rooted in ideological pre-commitment rather than observation. The very term 'consumer',

⁴M. Barnes, 'Authoritative Consumers or Experts by Experience? User Groups in Health and Social Care', in R. Simmons, M. Powell and I. Greener (eds), *The Consumer in Public Services: Choice, Values and Difference* (Bristol: Polity Press, 2009), 220–1.

⁵Summarized in A. O. Hirschman, *Exit, Voice and Loyalty: Responses to Decline in Firms, Organizations and States* (Cambridge, MA: Harvard University Press, 1970), 120–3.

⁶J. Le Grand, *The Other Invisible Hand: Delivering Public Services Through Choice and Competition* (Princeton: Princeton University Press, 2007), 98–101, 118–24.

⁷J. Le Grand, 'The Politics of Choice and Competition in Public Services', *The Political Quarterly*, 2007, 78, 2, 212.

⁸G. Brown, 'Speech on the National Health Service', 7 January 2008, <http://news.bbc.co.uk/1/hi/uk_politics/7175083.stm>, accessed 23 February 2011.

many health care experts have argued, 'derives from market economics rather than the sphere of state-citizen relations', since 'people act as consumers when they pursue their own preferences, satisfying their wants in line with their ability to pay'.⁹ Academic hostility to the 'consumerist' concept, for instance, often comes to some extent from a neo-Marxist distaste for what Raymond Williams termed the 'keyword' of 'consumption' itself. American, capitalist and bourgeois, he thought of 'consumerism' as an illusion created by producers rather than users, and designed to encourage purchase and waste—a concept detectable in objections to unused marginal capacity among hospital specialisms.¹⁰

The main problem with such debates is that they have too often ignored historical viewpoints as to what 'choice' itself means. They have been conducted instead within economic frameworks of individual 'choice'—failures which this article, along with others, will attempt to rectify.¹¹ 'Consumerism' need not, of course, be conceptualised in neo-liberal terms. John Maynard Keynes assigned a key role to the consumer in the maintenance of full employment and prosperity, though the Fabian thinkers Beatrice and Sidney Webb were less convinced. The Webbs argued that participatory co-operatives, a 'participatory' form of consumerism, would eventually be overtaken and replaced by state consumerism, which would only provide services such as the cable network, the post and the rail system. The latter would, however, never be as democratic as the former.¹²

The Webbs' ambivalence, of course, demonstrates the deep-seated and multi-faceted nature of the consumerist concept and its surrounding projects, though their fears should not be taken to mean that the idea was taken up more on the Right than the Left. As Hilton has pointed out, groups such as the Consumer Association have proved paradoxically more successful when mounting political campaigns than they have while acting on behalf of individual consumers of specific goods.¹³ Most of the Nordic countries, hardly exemplars of neo-liberal individualism, established advisory services for home economics in the inter-war period, and then fully-fledged consumer councils in the post-war era. These structures tended to become increasingly corporatist and identified with state social welfare objectives as time wore on.¹⁴ Consumer pressure groups within health care—so defined because they operate on behalf of sufferers with one single disease, or for a constellation of similar groups—are often consciously campaigning political

⁹J. Allsop and K. Jones, 'Withering the Citizen, Managing the Consumer: Complaints in Healthcare Settings', *Social Policy and Society*, 2008, 7, 2, 234.

¹⁰R. Williams, *Keywords: A Vocabulary of Culture and Society* (London: Fontana, 1976), 79.

¹¹M. Powell, 'Quasi-Markets in British Health Policy: A *Longue Durée* Perspective', *Social Policy and Administration*, 2003, 37, 7, 725–41.

¹²F. Trentmann, 'The Modern Genealogy of the Consumer: Meanings, Identities and Political Synapses', in J. Brewer and F. Trentmann (eds), *Consuming Cultures, Global Perspectives: Historical Trajectories, Transnational Exchanges* (Oxford: Berg, 2006), 22–3, 32, 46–7; J. Vincent, 'The Moral Expertise of the British Consumer, c.1900: A Debate Between the Christian Social Union and the Webbs', in A. Chatriot, M.-E. Chessel and M. Hilton (eds), *The*

Expert Consumer: Associations and Professionals in Consumer Society (Aldershot: Ashgate, 2006), 44–5.

¹³M. Hilton, *Consumerism in Twentieth-Century Britain: The Search for a Historical Movement* (Cambridge: Cambridge University Press, 2003), 336–7.

¹⁴K. Ilmonen and E. Stø, 'The "Consumer" in Political Discourse: Consumer Policy in the Nordic Welfare States', in P. Sulkunen, J. Holmwood, H. Radner and G. Schulze (eds), *Constructing the New Consumer Society* (Basingstoke: Macmillan, 1997), 198–9; I. Theien, 'Shopping for the "People's Home": Consumer Planning in Norway and Sweden after the Second World War', in A. Chatriot, M.-E. Chessel and M. Hilton (eds), *The Expert Consumer: Associations and Professionals in Consumer Society* (Aldershot: Ashgate, 2006), 146–8.

groups, led by relatively small numbers of committed organisers and volunteers.¹⁵ They also exhibit a relatively enlightened balance between male and female members (though they do less well in terms of representing racial minorities), maintaining a dense and powerful network of links with other consumer representatives and with more progressive doctors.¹⁶

The need for a more sensitive history of the 'consumer' is especially evident in terms of the social history of medicine, since struggles over the idea of individual representation, control, voice, choice and complaint have been evident for many years. 'Internal markets' are hardly neutral arbiters of personal service selection. The neo-liberal New Public Management of the 1980s, one particular variant of managed consumerism, in fact gave more power to *doctors* rather than patients in the health sphere, albeit within the clearly defined limits of centrally-determined policies and targets.¹⁷ For a new breed of doctor-manager was now expected to manage scarcity, picking and choosing between end-use providers, rather than patients themselves—perhaps guided by an increasingly influential and detailed code of medical ethics that was hardly amenable to patient access and information.¹⁸ Clearly this was a long way from the 'revolt of the laity' that opponents of doctors' power imagined would issue from more assertive patients in the 1970s.¹⁹

Responsibility for oneself and one's own physical health, for instance through diet and exercise, became ever more important in popular discourse during the late twentieth century—pushing health problems, and their attendant anxieties, back onto the individual.²⁰ Such developments help to explain some of the hostility towards 'consumerism' observable in the literature, an ideological predisposition that has obscured more than it has revealed. Few of the concepts examined here—government policy as a drive to deepen state knowledge, administration as the social protection of the vulnerable, or 'participation' throughout policy making—have been truly unpackaged. Such efforts seem well overdue, especially because Ministers and civil servants are usually advised by historical amateurs or self-interested policy entrepreneurs at best, or informed by personal prejudice and half-remembered undergraduate history at worst. New Labour's relatively unconvincing attempts to evoke the cooperative and mutualist tradition in favour of their own brand of managerialist reform is just one instance among many such failings over the last few years.²¹

¹⁵C. Bonell and M. Hilton, 'Consumerism in Health Care: The Case of a UK Voluntary Sector HIV Prevention Organization', *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, 2002, 13, 1, 34–5.

¹⁶R. J. Baggott, J. Allsop and K. Jones, *Speaking for Patients and Carers: Health Consumer Groups and the Policy Process* (Basingstoke: Palgrave Macmillan, 2004), 130–5; J. Allsop, K. Jones and R. Baggott, 'Health Consumer Groups: A New Social Movement?', *Sociology of Health and Illness*, 2004, 26, 6, 743.

¹⁷See J. Clarke, J. E. Newman, N. Smith, E. Vidler and L. Westmarland, *Creating Citizen-Consumers* (London: Sage, 2006), 21.

¹⁸R. Cooter, 'The Resistible Rise of Medical Ethics', *Social History of Medicine*, 1995, 8, 2, 260–1.

¹⁹R. Hugman, 'Consuming Health and Welfare', in R. Keat, N. Whiteley and N. Abercrombie (eds), *The Authority of the Consumer* (London: Routledge, 1994), 214–15.

²⁰R. Bunton, 'Popular Health, Advanced Liberalism and Good Housekeeping Magazine', in A. Petersen and R. Bunton (eds), *Foucault, Health and Medicine* (London: Routledge, 1997), 226–7, 232–3.

²¹V. Berridge, 'History Matters? History's Role in Health Policymaking', *Medical History*, 2008, 52, 3, esp. 313–18.

NHS 'consumerism': the need for more accurate histories

The political and economic discussion about NHS reform has so far been conducted around a caricature Martin Gorsky has rightly complained about: 'a fairly stable institution in its early decades, which then entered a period of sustained reform characterised by the incursion of market disciplines'.²² Some writers have indeed conceptualised the NHS before the 1980s internal market as a 'bleak habitat for the would-be consumer', a concept this article will also challenge.²³ Those clean temporal and analytical lines of argument are misguided. As Rob Baggott and many others have made clear, any arguments attempting to separate the concepts of citizenship and consumerism miss those ideas' 'complex' and 'blurred' reality, making them harder to locate in the historical record, though they were more pervasive than immediately apparent.²⁴ Matthew Hilton suggests, indeed, that the 'consumer society' overall 'was an amorphous entity in which many organizations had an interest'.²⁵ And as Martin Powell and his collaborators have noted, even such closely related words as 'consumer' and 'customer' are in this debate 'rarely defined, often conflated and used interchangeably'.²⁶ Frank Mort has similarly demonstrated how 'the agendas and rhetorics of democracy and consumerism have a more complex and inter-related history than is usually understood'; indeed, they 'are intimately related'.²⁷

For most of the post-Second World War era, fundamentally different ideas as to the meanings of 'the consumer', expertise, efficiency and consultation co-existed with these competitive models at one and the same time—as indeed they had in the pre-NHS health system.²⁸ Marketised, monetarised but also solidaristic forms of provision were also of long-standing, enduring even after the creation and during the most popular periods of the post-war welfare state—as Gorsky's work on local mutual insurance schemes, covering for instance dental and ophthalmic work, has demonstrated.²⁹ Such organisations' very existence and representative government does demonstrate the ever-unstable boundary between the medical 'market' and the healthcare 'consumer'. Understanding this point should permit a more nuanced and in the end more analytical approach than has hitherto been possible among the more ahistorical commentators.

²²M. Gorsky, 'The British National Health Service 1948–2008: A Review of the Historiography', *Social History of Medicine*, 2008, 21, 3, 440.

²³N. North, 'Consumers, Service Users or Citizens?', in N. North and Y. Bradshaw (eds), *Perspectives in Health Care* (Basingstoke: Macmillan, 1997), 134.

²⁴R. Baggott, 'A Funny Thing Happened on the Way to the Forum? Reforming Patient and Public Involvement in the NHS in England', *Public Administration* 83, 3 (2005), 534–5. See also C. Charles and S. De Maio, 'Lay Participation in Health Care Decision Making: A Conceptual Framework', *Journal of Health Politics, Policy and Law*, 1993, 18, 4, esp. 889.

²⁵M. Hilton, 'Consumers and the State since the Second World War', *The Annals of the American Academy of Political and Social Science*, 2007, 611, 1, 68.

²⁶M. Powell, I. Greener, I. Szmigin, S. Doheny and N. Mills, 'Broadening the Focus of Public Service

Consumerism', *Public Management Review*, 2010, 12, 3, 324.

²⁷F. Mort, 'Competing Domains: Democratic Subjects and Consuming Subjects in Britain and the United States since 1945', in F. Trentmann (ed.), *The Making of the Consumer: Knowledge, Power and Identity in the Modern World* (Oxford: Berg, 2006), 226.

²⁸I. Greener, 'Towards a History of Choice in UK Health Policy', *Sociology of Health and Illness*, 2009, 31, 3, 309–24.

²⁹M. Gorsky, J. Mohan and T. Willis, 'From Hospital Contributory Schemes to Health Cash Plans: The Mutual Ideal in British Health Care after 1948', *Journal of Social Policy*, 2005, 34, 3, esp. 450–8; M. Gorsky and J. Mohan with T. Willis, *Mutualism and Health Care: British Hospital Contributory Schemes in the Twentieth Century* (Manchester: Manchester University Press, 2006).

The early NHS in fact very rarely exhibited the monolithic characteristics that have been attributed to it. Elements of collective and personal financial choice were of course preserved in Part I of the 1911 National Insurance Act by retaining self-help mutual insurance societies to administer the Act, as well as leaving those on higher incomes to continue covering themselves. General practitioners' payment per patient also survived into the era of the NHS itself.³⁰ Patients have had the right to choose their GP since 1913, and doctors have been able to send their patients to any hospital they chose since the creation of the NHS.³¹ Although these systems were often bracketed with 'consumerist' concepts in terms of individuals' choices made between services and providers, or dismissed as 'holdovers' from a previous system after the creation of the NHS, they often contained very different meanings. Consumerism—including patient consumerism—can be conceptualised in many ways, including as a social movement, a way of life or an ideology.³²

From the early 1960s onwards, the concept of 'consumerism' within the NHS was organised around the notion of provision that was seen to be collective or collectivist in the sense that it implied costs and benefits, and rights and responsibilities, shared among all citizens, rather than individual choice.³³ This discourse was itself hardly unproblematic, of course, and it might involve direct or indirect input into policy making; and proactive or reactive service users.³⁴ But it was very different from the emphasis on each particular patient encouraged from 1979 onwards. It was only during the Thatcherite reforms of the health services during the 1980s that the concept took on its later neo-liberal meaning, as Alex Mold has made quite clear.³⁵ At every point 'consumerist' discourses overlapped, collided and combined with one another—partly because it was difficult to link the moment of choice, in a doctor's surgery, to a health care 'end' point that has always remained a rather slippery concept. Consumer choices became, in post-structuralist terms, a symbol without meaning, wearing out as rapidly as physical consumerist goods or fashions. These facts could make for strange bedfellows.³⁶

American historians, for instance Nancy Tomes, have of course been acutely aware of this facet of health policy, perhaps due to the emergence of a literature on 'the consumer' across a much wider contemporary front.³⁷ But there are also important examples of what might be done with such narratives in the British context. In this respect the work of Mold and

³⁰J. C. Riley, *Sick, Not Dead: The Health of the British Workingman during the Mortality Decline* (Baltimore: Johns Hopkins University Press, 1997); B. B. Gilbert, *The Evolution of National Insurance in Great Britain* (London: Michael Joseph, 1966); A. Digby, *Making a Medical Living: Doctors and Patients in English Market for Medicine, 1720–1911* (Cambridge: Cambridge University Press, 1994).

³¹Powell *et al.*, 'Broadening the Focus', 328.

³²I. Shaw and A. Aldridge, 'Consumerism, Health and Social Order', *Social Policy and Society*, 2003, 2, 1, 35; S. Harrison and R. McDonald, *The Politics of Healthcare in Britain* (London: Sage, 2008), 105–7.

³³See a similar definition juxtaposed with New Labour's views in E. Shaw, 'The Consumer and New Labour', in Simmons, Powell and Greener (eds), *Consumer in Public Services* (note 4), 33–4.

³⁴J. Q. Tritter, 'Revolution or Evolution: The challenges of Conceptualizing Patient and Public Involvement in a Consumerist World', *Health Expectations*, 2009, 12, 3, figs. 1–2, 277.

³⁵A. Mold, 'Patient Groups and the Construction of the Patient-Consumer in Britain: An Historical Overview', *Journal of Social Policy*, 2010, 39, 4, 506; Mold, 'Margaret Thatcher's Britain', esp. 510–11.

³⁶P. Sulkunen, 'The New Consumer Society: Rethinking the Social Bond', in Sulkunen, Holmwood, Radner and Schulze (eds.), Sulkunen, *et al.*, *Constructing the New Consumer Society*, 10.

³⁷N. Tomes, 'Merchants of Health: Medicine and Consumer Culture in the United States, 1900–1940', *Journal of American History*, 2001, 88, 2, esp. 546–7; also J. A. Greene, 'Attention to "Details": Etiquette and the Pharmaceutical Salesman in Postwar America', *Social Studies of Science*, 2004, 34, 2, 271–92.

Christine Hogg is central on the course of ideological and policy change, analysing as they do debates about patients' rights, the foundation of pressure groups such as the Patients Association (PA), access to medical records and the role of patient and community forums—all key parts of the fissiparous consumer agendas of the post-war era.³⁸ Such authors' work has allowed us to begin to understand prior alternatives to those neo-liberal outcomes popularised in the 1980s and 1990s, foremost among which was the idea that patients should be involved *in their own care* rather than just choosing between providers, with attendant clinical and psychological gains. This essay seeks to track and understand how Westminster and Whitehall reacted to the trends and pressures that these authors have so expertly portrayed in the wider social and political context, whether British or Transatlantic.

The authors of more recent milestones such as New Labour's 2000 NHS Plan and the 2010 Coalition Government's first Health White Paper (and subsequent Health and Social Care Act) have ignored much of this prior history, just as writers on the Left have often underplayed and attempted to ignore 'consumerist' histories: instead, the authors of such texts recognised but also attempted to exacerbate the deep-seated ambiguities between these overlapping ideas, endeavouring to characterise NHS history as marked out by a crude conflict between a slow, unresponsive state-sponsored mentality and a more focused, dynamic set of specific demands that neo-liberal governments would now champion. They very much relied on the quasi-historical categories Gorksy has complained of in order to do so.³⁹

However, such contiguous ideas, and the continual compromises between them, actually help explain the course of policy throughout the life of an NHS whose reform agendas have always been far less centrally concerned with the individual figure of the 'consumer' than the last decades' discourses imply. No socio-medical concept, as Roger Cooter has pointed out, can ever 'be outside the social, political and ideological context in which it is conducted'—still less when it concerns the nexus between individual, group and state which gave late twentieth century politics their particular flavour in the developed world.⁴⁰ In the post-war welfare state, 'consumerism' carried meanings including the enforcement of collective standards, the prevention of professional abuse, and the right to voice opinions about synoptic rather than individualistic decisions. This article will now turn to each of these fields in turn, all the while—as John Clarke and his collaborators have recommended for a slightly later period—keeping these 'multiple dynamics' pragmatically in view.⁴¹

The influence of collective 'consumerism': NHS knowledge and surveillance

From the early 1960s onwards, and especially from about the time of the 1961 Hospital Plans that promised so much more state care and spending, the phenomenon of a more

³⁸Mold, 'Patient Groups', e.g. 510–11; C. Hogg, *Healthy Change: Towards Equality in Health* (London: Socialist Health Association, 1991), 62–5.

³⁹Cm. 4818-I, *The NHS Plan* (London: HMSO, 2000), 26; Cm. 7881, *Equity and Excellence: Liberating the NHS* (London: HMSO, 2010), 3. See the supporting document Ministry of Health, *Local Democratic*

Legitimacy in Health: A Consultation on Proposals (London: HMSO, 2010), 2–4.

⁴⁰R. Cooter, 'The Ethical Body', in J. V. Pickstone and R. Cooter (eds.), *Medicine in the Twentieth Century* (Amsterdam: Harwood Academic, 2000), 451–67.

⁴¹Clarke et al., *Citizen-Consumers*, 23.

demanding and discerning set of 'consumers' was particularly pronounced in the field of welfare provision. Although the greatest absolute *number* of patient groups was founded in the late 1970s and early 1980s, their number took off *proportionately* from a low base during the 1960s.⁴² The think tank Political and Economic Planning conducted a questionnaire-based survey of 734 families 'from the consumer point of view' in 1961, revealing a large reservoir of unmet and unasked-for needs beneath the surface of welfarist 'success'.⁴³ Across the health care field in particular, new groups such as Aid for the Elderly in Government Institutions (AEGIS), the Association for Improvements in the Maternity Services, Help the Aged and the National Association for the Welfare of Children in Hospital proliferated rapidly.⁴⁴

These groups' intention was clear. They existed to lobby for their members' interests—or at least for those they sought to represent. Though not usually associated with health care politics in particular, the Consumers' Association was gradually to become one of the most powerful representatives of this general trend. Michael Young, one of its key founders and its first director, had already helped to found the welfare state itself. As the head of the Labour Party Research Department in the 1940s, he had drafted much of the Party's 1945 manifesto.⁴⁵ Young would go on to set up the College of Health in 1983, a body that attempted to address what he saw as the imbalance of power between doctors and patients. Its public information campaigns, and its journal *Self Help*, became another way in which patients and the public were invited to interrogate medical advice.⁴⁶

His Institute of Community Studies, founded in 1953, was an early innovator in the health field. Young's research associates, such as Enid Mills and Ann Cartwright, approached health care research through very close attachment to—and qualitative research alongside—patients and ex-patients.⁴⁷ The Research Institute which they set up alongside their Association conducted a survey of general practice 'from the consumer's standpoint' in 1963—although, like the Political and Economic Planning study of 1961, the document envisaged determining *communal* demand and *collective* decisions by reference to these surveys. They certainly did not imagine that the word 'consumer' would be taken to mean a sick individual themselves choosing between services: in this respect the words 'taxpayer', 'citizen', 'the public' and 'consumer' were used interchangeably.⁴⁸

Which?, the magazine of the Consumer Association, had itself long been active in the field of commenting on the quality of health care in Britain through evidence-based

⁴²B. Wood, *Patient Power: The Politics of Patients Associations in Britain and America* (Buckingham: Open University Press, 2000), table 3.1, 36; K. Jones, R. Baggott and J. Allsop, 'Influencing the National Policy Process: The Role of Health Consumer Groups', *Health Expectations*, 2004, 7, 1, table 2, 21.

⁴³Political and Economic Planning, *Family Needs and the Social Services* (London: Allen and Unwin, 1961), e.g. 2, 17, 194–7.

⁴⁴C. Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 1998), 68.

⁴⁵P. Thane, 'Michael Young and Welfare', *Contemporary British History*, 2005, 19, 3, 295.

⁴⁶M. Young, 'The Four Purposes and Six Methods', *Self Health*, 1983, 1, e.g. 4.

⁴⁷A. Briggs, *Michael Young: Social Entrepreneur* (Basingstoke: Palgrave Macmillan, 2001), 137, 152.

⁴⁸Research Institute for Consumer Affairs, *General Practice: A Consumer Commentary* (London: RICA, 1963), 3, 24–6.

choice. Its public work began in 1966, with an article covering hospital appointments. This surveyed the extent to which hospitals were complying with a Ministry target that no more than a quarter of waits in out-patient departments should be longer than half an hour—again, a societal and a state-determined goal. *Which?* used data from the Nuffield Trust to show that only eleven hospitals could meet this target, and that 45 per cent of patients were waiting more than half an hour. It did not, however, name the particular hospitals involved.⁴⁹ The magazine carried on with its health-oriented articles, and their relatively collectivist focus: an October 1972 editorial about the inception of CHCs called for them to take on the wide powers of consultation, investigation and censure enjoyed by regional consumer groups in the nationalised industries.⁵⁰

Similar work continued to influence public demands and perceptions of the NHS in the 1970s, centring first on the provision of maternity services which had always contained an unusually high level of choice at the local level because of the heavy involvement of voluntary bodies and small municipal homes. The growth of obstetrics as a scientific discipline on its own account, as well as its increased standing and numbers within the medical profession, helped move the concept of individual choice even closer to the centre of the stage. The specialism gained its own Royal College in 1947, rapidly increasing its membership and influence. A new wave of post-war doctors increasingly insisted, often in the most vituperative terms, on childbirth taking place in hospital. A reaction in favour of homeliness, holistic methods and (ultimately in the 1970s and the 1980s) home birth became inevitable—developments indicated by the creation of the Natural Childbirth Association, later the National Childbirth Trust, in 1956.⁵¹

In the meantime, putative or new parents became all the more assertive about the hospital care they had been told was so desirable. The aforementioned Association for Improvement in Maternity Services, and the National Association for the Welfare of Children in Hospital, are good examples of increased pressure on this front.⁵² The social anthropologist and natural childbirth activist Sheila Kitzinger published the first edition of her *Good Birth Guide* in 1979. A sample of 1,759 letters from new mothers themselves formed the backbone of Kitzinger's research: any hospital receiving more than five very positive reviews received a 'star' in the main list.⁵³

There were a number of other reasons for the focus on maternity services, most of them unrelated—or only tangentially linked—to the individualist concept of prospective parents choosing types of childbirth or hospitals. Perhaps more importantly, maternity patients tended not to fit the general schema of NHS 'consumers'. Rather than being old, ill and frail, they were usually young, fit and healthy.⁵⁴ Varied geographies of care in this specialism were and indeed are an international phenomenon, partly explained by the relatively low status of midwifery and 'women's health' generally enjoyed in the medical

⁴⁹'Hospital Appointments', *Which?*, 1966, 9, 30–1.

⁵⁰National Archives of the United Kingdom, Kew, London (hereafter TNA) MH 159/419, Dodds to Gedling, 16 October 1972.

⁵¹M. Tew, *Safer Childbirth? A Critical History of Maternity Care* (3rd edn, London: Free Association Books, 1998), 61, 234–5.

⁵²B. Watkin, *The National Health Service: The First Phase, 1948–1974 and After* (London: Allen and Unwin, 1978), 119; Wood, *Patient Power*, 95.

⁵³S. Kitzinger, *The Good Birth Guide* (London: Croom Helm, 1979), 14, 18–19.

⁵⁴*Ibid.*, 10.

profession.⁵⁵ More specifically as regards post-war Britain, the birth rate rose very quickly in the 1960s, making for a very rapid expansion in the number of maternity beds that were then left empty when the birth rate fell again later in that decade. The range of choice was thus wider than in some other specialisms.⁵⁶ This phenomenon itself also caused enormous variations in the standard of care.⁵⁷

One key element of consumerist approaches to public services relied on work with and for groups, rather than individuals: the increased use of public surveys and official inquiries to find out what the 'consumers' of health care required, surveys that were at one and the same time important in framing the idea of more rational economic planning both for companies and for governments.⁵⁸ There was, indeed, a dearth of sheer information about complaints and their handling in the NHS. When the PA came to investigate this problem in the mid-1970s, it found that little official work had been done on categorising different types of complaint, and that indeed sociologists were finding it very hard to secure funding for any such work. The PA had no money to mount a full-scale tabulation of its own, though it did pay for the Consumer Association to computerise a small pilot study in 1981 and 1982.⁵⁹

Most of those surveys now proposed were not, however, explicitly couched in the language of *individual* consumer rights, still less in terms of patient choice. Concern as to the efficacy of official choices and policy, or with *post-policy* failure, was much more clearly to the fore. The social policy academics Rudolf Klein and Phoebe Hall (later replaced on the project by Janet Lewis) approached the Department of Health and Social Security (DHSS) about the possibility of a wide-ranging study of public attitudes in 1973. They were clear that their work intended to uncover 'the expectations and problems—and the possible implications for other ... areas of public policy—connected with the mixture of complaints procedures and consumerism that now looks like developing in the field of health and personal social services'.⁶⁰ The Department accepted the idea with alacrity. They were, for one thing, concerned that if they did not, it would be impossible to judge independently the success of their own initiatives—and in particular the creation of CHCs in 1974. The Department accepted the idea with alacrity, for it urgently desired to be increasingly 'well informed', and the level of what they did not know regarding who was serving on the CHCs, what role they were trying to find for themselves, and the basis on which they were appointed, was the final major reason why the Klein and Hall study went ahead.⁶¹

So interested were academics in this new experiment that national and local investigations also went ahead in Scotland, Yorkshire, Northern England, the West Midlands,

⁵⁵See the remarks on Spain and Scandinavia in J. Fry, W. Arthur and J. Farndale, *International Medical Care: A Comparison and Evaluation of Medical Care Services Throughout the World* (Oxford: Medical and Technical Publishing, 1972), 37, 46, 51.

⁵⁶G. O'Hara, "'We Are Faced Everywhere With A Growing Population": Demographic Change and the British State, 1955–64', *Twentieth Century British History*, 2004, 15, 3, 253–4.

⁵⁷D. Paige and K. Jones, *Health and Welfare Services in Britain in 1975* (Cambridge: Cambridge University Press, 1966), 16.

⁵⁸J. Lueruz, *Economic Planning and Politics in Britain* (London: Martin Robertson, 1975), 324.

⁵⁹Wellcome Library, London, Special Collections, Papers of the Patients Association (hereafter Wellcome PAT) D/13/1, Hamnett to PA, Robinson to Acheson, 20 September, 2 November 1976, Sand to Ackroyd, 4 December 1981, Ackroyd to Sand, 9 December 1981.

⁶⁰TNA MH 166/1191, Isserlis to Rogers, 19 February 1973.

⁶¹*Ibid.*, Hulme to Foster, 30 May 1973, and CSSP, Community Health Council Project, steering group working paper no. 1, 7 February 1974.

Swansea and Merseyside. The Office of Health Economics conducted its own research, and the Government funded further research by Brunel University's Professor Elliot Jaques—who had helped advise on management after reorganisation—into how NHS managers were working with CHCs.⁶² As regards consumerism, though, the presence on the steering group for this research of Mark Abrams is particularly notable.⁶³ Abrams was the Labour Party's private pollster for most of the 1950s and 1960s, as well as a social scientist of some note in his own right as the founder of the Market Research Society—although his interest in health care and the interests of the vulnerable later led him to become Director of Age Concern, at the age of seventy, in 1976. His presence further helps to bring the collectivist elements of consumerism more sharply into focus, for Abrams imagined such exercises bolstering the popularity of the social democratic state through more sensitive and plural provision, rather than fostering personal assertion and competition.⁶⁴ Whatever *rhetoric* such key policy actors adopted in terms of 'consumerism', what they often meant was the creation of a more humanistic and responsive social democracy.

'Consumerism' and the pressure of scandal

The relative complacency of DHSS civil servants had already been shaken by scandals that emerged during the late 1960s—the next of our 'consumerist' rhetorics that provides us with a more complicated picture of consumerist ethics than has previously been available. This was the point at which post-war optimism as to the efficacy of medical care was giving way to scepticism and doubt. The thalidomide scandal that broke in 1962 raised doubts about modern drugs' supposedly wondrous efficacy. Maurice Pappworth's revelations about doctors' experiments on unknowing patients, 'Human Guinea Pigs: A Warning', was published that same year.⁶⁵ The PA was set up by Helen Hodgson in 1963 specifically as a reaction to Pappworth's revelations.⁶⁶

The immediate political explosion was linked to the quality—or otherwise—of long-term care for those who could not speak up for themselves. AEGIS wrote to *The Times* in 1965, complaining about the treatment of old people in hospitals.⁶⁷ Barbara Robb, a key member of AEGIS, then wrote an even more damning indictment—entitled *Sans Everything*—of just how untrained and unsympathetic nursing staff in such institutions could be.⁶⁸ Appalling conditions were then uncovered at a hospital for the mentally ill sited at Ely, near Cardiff. Officials were therefore struggling to discover for themselves what the actual state of the Service—especially that experienced by the long-term sick and the elderly—really was. 'They have been struck', one official wrote, 'by the absence of any reliable estimate of the numbers involved and perhaps particularly

⁶²TNA MH 166/1191, Foster to Wilson, 23 May 1974, Foster memorandum, 11 June 1974; TNA MH 166/1192, Harper to Allsop, 12 February 1975.

⁶³TNA MH 166/1192, Foster to Torrie, 12 September 1974.

⁶⁴On Abrams see recently J. L'Etang, *Public Relations in Britain: A History of Professional Practice in the Twentieth Century* (Mahwah, NJ: Lawrence Erlbaum, 2004), 31; S. Fielding, 'Rethinking Labour's 1964

Campaign', *Contemporary British History*, 2007, 21, 3, 315, 320.

⁶⁵Cooter, 'Ethical Body', 458.

⁶⁶Mold, 'Patient Groups', 510.

⁶⁷'Old People in Mental Hospitals', Letters to the Editor, *The Times*, 10 November 1965.

⁶⁸B. Robb, *Sans Everything: A Case to Answer* (London: AEGIS, 1967), e.g. xiv–xv.

about the elderly'.⁶⁹ The Ministry was in this respect continuing initiatives that dated back to the 1961 Hospital Plan and its 1962 local health and welfare equivalent. Both of these exercises had revealed massive gaps in the Government's knowledge, which it had set out to fill, albeit in a gradual and piecemeal manner.⁷⁰

Work on the wider situation had started just before the Ely scandal had erupted, although after the AEGIS agitation had already begun. Though it would take some time to implement a full-scale national Social Survey study of provision for the chronic sick and handicapped, the Ministry had already asked local authorities for more information on the age and health problems of this group.⁷¹ They also sought to draw in Margot Jeffreys of Bedford College in London (later to become part of Royal Holloway College) as an expert in general practice and old age.⁷² Jeffreys and her team from Bedford College's Sociology Department had already prepared an interim report that showed how survey methods might break the previously-opaque category of 'physical handicap' into more useful statistics covering age, region, locality and (crucially) different measures of physical mobility.⁷³

Another reaction to Ely was another look at that apparently most 'consumerist' of customer or patient reactions: the complaints procedure. The situation in this field was confused, and the administrative structure fragmentary. It remained, for instance, rather difficult to complain about an individual General Practitioner's behaviour. Family Practitioner Committees (FPCs), the bodies holding GPs' contracts, would look into such cases, but only on an individual basis. The General Medical Council (GMC), for its part, generally dissuaded complainants unless doctors were judged in breach of contract by the FPC, or indeed of criminal practices or negligence in the courts. Even then, most of the breaches of contract investigated by the FPC did not overlap with medical 'misconduct' as defined by the GMC, and *vice versa*. Hospital doctors could be suspended immediately following a Circular to this effect in 1961; but the procedure for actually reinstating or dismissing them could take many years.⁷⁴

A high court judge, Sir Michael Davies, was asked to look into complaints in hospitals, and recommended a four-stage complaints process, with each subject to appeal, and which would include increasing numbers of outside experts as the case wore on and became more serious.⁷⁵ The Committee's recommendations, including the publication of complaints procedures, were circulated in draft notes during 1976 and 1978 before some of them were finally contained in a 1981 DHSS Circular on the subject.⁷⁶ Even this relatively tardy action was only felt necessary after a sequence of critical reports

⁶⁹TNA RG 40/310, Pronger to Moss, 1 May 1967.

⁷⁰G. O'Hara, *From Dreams to Disillusionment: Economic and Social Planning in 1960s Britain* (Basingstoke: Palgrave Macmillan, 2007), 183–4, 194–8.

⁷¹TNA RG 40/310, Pronger to Moss, 25 May 1967, and enclos., 31 December 1966.

⁷²For some of her contemporary work see D. Irvine and M. Jeffreys, 'BMA Planning Unit Survey of General Practice 1969', *British Medical Journal*, 27 November 1971.

⁷³TNA RG 40/311, Buglass, Jeffreys, Warren report, 'The prevalence of physical disability', May 1966.

⁷⁴C. N. L. Hogg, 'Health', in N. Deakin and A. Wright (eds), *Consuming Public Services* (London: Routledge, 1990), 162, 165–6.

⁷⁵M. J. Johnson, 'Patients: Receivers or Participants?', in K. Barnard and K. Lee (eds), *Conflicts in the National Health Service* (London: Croom Helm, 1977), 91–2.

⁷⁶E.g. Wellcome PAT D/13/4, DHSS Circular, 'Health services complaints procedure', April 1978, DHSS Circular, 'Health services complaints procedure', April 1981.

issued from the new office of the Health Service Commissioner, an official appointed in 1973 despite a long campaign of obstruction by civil servants and doctors' representatives.⁷⁷

Only a relatively complacent section—far removed from Davies of the Select Committee's proposals—was included on clinical judgements, after the Joint Consultants' Committee (JCC) and the British Medical Association (BMA) had objected to many elements in the original Davies design. In the first instance of specifically *medical* complaints, two independent or 'outside' consultants would be appointed by the Regional Health Authority.⁷⁸ The PA, along with more radical consultants such as the orthopaedic surgeon Nigel Harris, condemned such plans as 'unbelievably complicated' and—even in their earlier, more interventionist forms—'unlikely to be regarded by the public as self-evidently "independent" given that the RHS is part of the managerial hierarchy'.⁷⁹ Even *The Times* thought the JCC's initial proposals 'almost embarrassingly inadequate'.⁸⁰ The second of our themes most evident from the era of the advanced welfare state—that of collective security—was still struggling in the face of professional power by the time the British government became increasingly neo-liberal and individualist in tone.

Community Health Councils: a more 'participatory' National Health Service?

'Participation' was most notably adopted in the British policy arena in the fields of urban policy and welfare benefit payments, from whence they had emerged in their original American context: Labour's Community Development Programme involved mixed teams of officials and academics working to combat 'multiple deprivation' in cities blighted by economic decline.⁸¹ The 1970s witnessed a further sequence of small-scale experiments both within city redevelopment initiatives and to help reform benefit provision.⁸² Race and primary education were two further clusters of concern which produced new work on these lines: British sociologists and planners believed they could learn much in terms of race relations and community education in 'deprived areas' from US innovation in those fields. Educational Priority Areas and the Community Development Programme both issued in 'inner area studies' during the 1970s.⁸³

But the idea gradually gained traction in the NHS as well. The removal of all hospital functions from local authorities at the creation of the NHS in 1948 had removed any

⁷⁷*Ibid.*, Fletcher, DHSS, to PA, 5 April 1978, Davies, DHSS, to Laverton, 1 November 1979. On the Ombudsman see G. O'Hara, 'Parties, People, and Parliament: Britain's "Ombudsman" and the Politics of the 1960s', *Journal of British Studies*, 2011, 50, 3, 692–3, 701, 702–3.

⁷⁸'Complaints Relating to Clinical Judgement', *British Medical Journal*, 22 November 1980; 'Way Found for Hospital Patients to Question Clinical Judgement', *The Times*, 6 February 1981.

⁷⁹Wellcome PAT D/13/4, PA memorandum, 'Comment On Report of the Committee on Hospitals Complaints Procedure', March 1974; N. Harris to PA, n.d., possibly 1980; E. Ackroyd, Letter, *British Medical Journal*, 13 December 1980. See L. Mulcahy, *Disputing Doctors: The Socio-legal Dynamics of Complaints*

about Medical Care (Maidenhead: Open University Press, 2003), 33–40.

⁸⁰'Consultants Agree on Complaints Procedure', *CHC News*, 26 February 1982.

⁸¹S. Fielding, *The Labour Governments 1964–70, Vol. I: Labour and Cultural Change* (Manchester: Manchester University Press, 2003), 208–9.

⁸²E.g. DHSS, *Social Security Users: Local Consultative Groups* (London: HMSO, 1978).

⁸³M. Clapson, 'The American Contribution to the Urban Sociology of Race Relations in Britain from the 1940s to the early 1970s', *Urban History*, 2006, 33, 2, 253–73; H. Silver and P. Silver, *An Educational War on Poverty: American and British Policy-making, 1960–1980* (Cambridge: Cambridge University Press, 1991), 187–209.

sense of local accountability in the most powerful and best-funded part of the service. A sense that this had created a 'democratic deficit' gradually increased across most non-medical observers in the 1960s.⁸⁴ 'Participation' had also become a newly interesting topic in health administration across the Atlantic during the passage of the comprehensive US health legislation known as Partnership for Health in 1966. American rhetoric on this subject was, indeed, the subject of warm words during the twentieth anniversary NHS conference itself.⁸⁵

Politicians' and officials' interest in participation came at the same time as patients were increasingly urged to take part in their own health—or lack of it. Not only were the public urged to embrace healthier lifestyles, as embodied for instance in 'self-help groups' set up by gamblers, alcoholics, mental health charities and sufferers from chronic conditions such as Myasthenia Gravis.⁸⁶ Doctors also began to involve their patients in 'patients' forums' that might help advise doctors on local people's views. Three quite independent experiments began in Wales, Bristol and Oxford: by 1981 there were 37 such bodies operating in England and Wales, and by 1985 there were 70.⁸⁷ Some of these groups had already organised over a hundred meetings, discussions and lectures.⁸⁸

The inception of CHCs in 1974 was certainly perceived as one of the most significant changes of the era in terms of 'participation'. It was here that the rhetoric of the late 1960s began to have its practical effect, quite apart from either discourses of social democratic responsiveness or the protection of the highly vulnerable, such as the elderly in long-term care. David Owen, himself a medical doctor and at this stage Minister of State for Health, hailed them as 'very important in orientating people toward a philosophy that health is not just something that is provided for by the NHS, but that each individual has a responsibility for his own well-being'.⁸⁹ The English White Paper explicitly introduced CHCs as 'bodies to represent the views of the consumer', involving a 'wider cross-section of local opinion' in decision making.⁹⁰ The Circular introducing them to managers hailed them as 'a new means ... of representing the interests of the community ... to those responsible for managing those services'.⁹¹

Most DHSS officials certainly did not share the radical views of many who advocated participatory democracy within the NHS. One made clear in his notes on the Bill that 'I see the Community Health Council as complementary to the District Management Team and working symbiotically with it. I think that "independence" is an illusory

⁸⁴C. Hogg, *Citizens, Consumers and the NHS: Capturing Voices* (Basingstoke: Palgrave Macmillan, 2008), 11–16.

⁸⁵DHSS, *Anniversary Conference*, 93–4.

⁸⁶D. Robinson and S. Henry, *Self-Help and Health: Mutual Aid for Modern Problems* (London: Martin Robertson, 1977), 46–56.

⁸⁷A. Richardson and C. Bray, *Promoting Health Through Participation: Experience of Groups For Patient Participation in General Practice* (London: Policy Studies Institute, 1987), 12–13.

⁸⁸J. Wood, 'Patient Participation in General Practice', in R. Maxwell and N. Weaver (eds), *Public Participation*

in Health: Towards a Clearer View (London: King Edward's Hospital Fund, 1984), 65.

⁸⁹'Change in Attitude to NHS Sought', *The Times*, 9 February 1976; 'Creating New Responsibility and Awareness for Patients', *The Times*, 14 February 1976.

⁹⁰Cmnd. 5055, *National Health Service Reorganisation: England* (London: HMSO, 1972), 27.

⁹¹TNA MH 166/1525, NHS Reorganisation Circular, 'Community Health Councils', final draft, 23 October 1973.

benefit ... ' Instead, it was initially thought that CHCs might perform their main and most valuable role in studying long-term local demand.⁹² Officials' aim was to make the NHS easier, not more difficult, to administer. Doctors, too, played a key role in this: the BMA asked the DHSS to include an 'admonishing' clause in the relevant NHS Circular, warning against NHS staff being 'diverted from their duties' by CHC investigations. Although drafters eventually thought this too harsh, a clause was inserted making it clear that 'there will be times when Service needs may have to take priority'.⁹³

CHCs found it very difficult to carve out a permanent niche within the NHS. Klein and Lewis' 1976 study eventually came to some rather disheartening conclusions, for they found the bodies' members often exclusive, elitist and constantly and deliberately at variance with local management teams.⁹⁴ Another survey by Lewis concluded in the mid-1980s that doctors, too, had become institutionally hostile to CHCs. Only four among 44 community physicians thought they were useful: others used terms such as 'bland', 'bothersome' or 'managers *manqués*' to describe their members.⁹⁵ CHCs had the right to be consulted about 'substantial' service alterations, but local administrators proved adept at denying that changes were 'substantial': there was no statutory definition of the term.⁹⁶ When the Brunel researchers organised conferences on 'community participation in the NHS' during 1975 and 1976, they found a good deal of frustration. 'Area Health Authorities (AHAs) felt jealous of the CHC's closer contact with patients', CHC members reported; there were no formal links with local authorities; and there was little real CHC involvement in planning for the future, leading to a 'rubber-stamp' role when they were presented with new schemes.⁹⁷

Even so, CHCs did gradually make a series of incremental gains for themselves. They gained the right to send a member to AHA meetings in 1975, though only as observers: and AHAs could exclude community health representatives from some discussions, for instance on personnel. Many CHC members were particularly vigorous and decisive, and the bodies did gradually accrue new powers. The Labour Government elected in 1974 granted them the statutory powers to obtain information, visit hospitals, and to be consulted over hospital closures.⁹⁸ When the Kensington, Chelsea and Westminster AHA proposed the redevelopment of St Mary's in Paddington, the local CHC employed medical sociologists and market researchers to mount a counter-proposal. Many CHCs developed good relationships with permissive bodies such as the Hospital Advisory Service, while others mounted extensive publicity and advertising campaigns on both the strengths and weaknesses of local provision. Several CHCs worked together, for instance, in a national campaign to help patients who were suffering side effects of the

⁹²TNA MH 159/419, Burbridge to Foster, 11 May 1973.

⁹³*Ibid.*, Foster to Hulme (possibly October) 1973.

⁹⁴R. Klein and J. Lewis, *The Politics of Consumer Representation: A Study of Community Health Councils* (London: Centre for Studies in Social Policy, 1976), 159–60.

⁹⁵J. Lewis, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health since 1919* (Brighton: Wheatsheaf, 1986), 146.

⁹⁶T. Millewa, J. Valentine and M. Calnan, 'Community Participation and Citizenship in British Health Care Planning: Narratives of Power and Involvement in the Changing Welfare State', *Sociology of Health and Illness*, 1999, 21, 4, 447–8.

⁹⁷TNA MH 166/1192, Notes on the Second Conference on Community Participation in the NHS, 5 February 1976.

⁹⁸Hogg, *Consumers*, 21.

heart drug Eraldin, during which they lobbied the manufacturers, ICI, and the Government.⁹⁹

Conclusions: the NHS 'consumer' in historical context

The concept of 'the consumer' was and is nowhere near as simple as its critics, or its enthusiasts as represented by the authors of the 2000 NHS Plan and the 2010 White Paper, seem to believe. It has always been made up of many strands, as Hirschman in fact predicted with his prescription for a 'variety of remedies, or a combination of them' in 1970.¹⁰⁰ This was never more the case than during the 1960s and 1970s, when the rights of surveyed groups, the rights of the vulnerable (including those exploited in long stay institutions), and the call for 'participation'—not the desires of individuals—were demonstrated as key concerns for public policy makers. Episodic 'choice' in its crudest forms bore the hallmarks of increasingly affluent and assertive retail behaviour, but *social* surveying, *collective* campaigning and policy participation sprang in different ways from social democratic transnationalism and ideas then current about the shape and validity of the public realm. The latter concept allowed thinkers on the Left to imagine how democracy itself might be regenerated via community organising and self-help American governmental techniques borrowed—via, for instance, the Government's Urban Programme and Educational Priority Areas—from that country's 'War on Poverty'.¹⁰¹

The participatory initiatives embodied in the CHCs did not, for the most part, actually change the modes in which most of the public actually experienced the NHS. Huge progress was undoubtedly made, especially on a case-by-case basis and at a local level. The combination of new complaints procedures, for instance the Health Commissioner or 'Ombudsman' as well as the CHCs, certainly, if slowly, changed some of the Service's internal dynamics. Even so, it remained the case, as we have seen, that novel experiments with public involvement and consultative action gained their greatest traction within the NHS at a policy level. Actual contacts with doctors were far less likely to change.

There were always inherent—and often explicit—conflicts between participatory and consumerist behaviour. Hogg has laid bare many of them in her recent book on the subject, but as we have seen such tensions were also noted at the time.¹⁰² These intense difficulties were as clear in the 1960s as they have been since the emergence of a Thatcherite 'internal market', rooted as much in conflicting theories of progress and reformism as in the administrative niceties of the NHS. New Labour's own 'consumerist' initiatives were similarly confused, continuously moving back and forth between 'participatory' citizenship, local and national representative networks and a more assertive individualistic language in terms of the Patient and Public Involvement Forums, the national patients' body and the Patient Liaison Services.¹⁰³ As CHCs gave way to these

⁹⁹R. Levitt, *The People's Voice in the NHS: Community Health Councils After Five Years* (London: King Edward's Hospital Fund, 1980), 32–7.

¹⁰⁰Hirschman, *Exit*, 123.

¹⁰¹G. Brager, H. Specht and J. L. Torczyner, *Community Organizing* (New York: Columbia University Press, 1973), e.g. 63; S. Fielding, 'Labour and the Demand

for "Participation", 1964–70', in J. Callaghan and I. Favretto (eds), *Transitions in Social Democracy: Cultural and Ideological Problems of the Golden Age* (Manchester: Manchester University Press, 2007), 136–9.

¹⁰²Hogg, *Consumers*, 87–9.

¹⁰³Baggott, 'Public Involvement', 539–43.

Forums, and then to Local Involvement Networks or LINks, Hogg noted that 'it is not clear what Government wants from LINks once you look beyond the rhetoric'—a sense of confusion reflected among members at a local level.¹⁰⁴ Official government publications could and did conjoin 'more choice', 'a louder voice', 'a sense of personal well-being' and 'the collective voice of people' in the same sentences. 'Choice' and 'voice' were constantly evoked by Cabinet Office and Department of Health publications without much delineation of either. The argument appeared to be that each might bolster the other. It is not a prospect much encouraged by the research into the 1960s and 1970s presented here.¹⁰⁵

All the more reason, mused those neo-liberals who would eventually dictate policy, and who sought to constrain costs and contain criticism at one and the same time, to downplay these dilemmas. Instead, they sought to graft elements of central direction onto 'social' or 'internal' markets.¹⁰⁶ Hostility towards the very concepts of 'choice' and 'consumerism' then followed quickly on the heels of those half-finished and deeply contested administrative revolutions. But a historical sense of how 'consumerism' might instead be fused with very different concepts of 'citizenship', social vulnerability and 'participation' might serve as a better point of departure for meaningful critiques of either the neo-liberal agenda or its critics. That will be no simple task. As David Marquand has put it, any 'new public domain', which defies cramped post-welfarist notions of 'the consumer', 'will need a lot of creativity, imagination and flexibility'.¹⁰⁷ But one starting point is to assert that 'consumerism' has always been surrounded and saturated with other, older and interpenetrating concepts which focus on actively taking part in groups and in societal change. It is a point that historians can and should make continuously, to the benefit of public policy, practitioners and patients alike.

¹⁰⁴C. Hogg, 'Patient and Public Involvement: What Next for the NHS?', *Health Expectations*, 2007, 10, 2, 131, 134.

¹⁰⁵Department of Health, *Our Health, Our Care, Our Say* (London: TSO, 2006), e.g. 7, 13, 159. See R. Simmons, J. Birchall, S. Doheny and M. Powell, 'Citizen Governance: Opportunities for Inclusivity in Policy and Policy-Making', *Policy and Politics*, 2007, 35, 3, 458–9.

¹⁰⁶T. Burden, 'Health Policy', in M. Mullan (ed.), *Policy-Making in Britain: An Introduction* (London: Routledge, 1995), 188–9; E. J. Evans, *Thatcher and Thatcherism* (2nd edn, London: Routledge, 2004), 65–9.

¹⁰⁷D. Marquand, *Decline of the Public: The Hollowing out of Citizenship* (Cambridge: Polity, 2004), 134.