Consumers enter the political stage?

The modernisation of health care in Britain and Germany

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Abstract

New governance practices associated wit the modernisation of health systems within Europe focus on equipping health consumers with more information and power in their interactions with clinicians. This paper uses material on health care reform in Britain and Germany to highlight ways in which consumerism is refracted through different institutional histories and current political projects. These give rise to different inflections on the meaning of consumerism, including the different associations of 'choice', and to different forms of consumer involvement as 'stakeholders' in health care systems.

Introduction

'Discriminating consumers' and 'accountable professionals' are at the heart of pan-European discourses on health reform in late modernity (Coulter and Magee, 2003). For example, the European Commission adopted a health and consumer protection strategy that had as one of

its objectives to "increase the ability of citizens to take better, informed decisions ('exercise real choice') about their health and consumer interests" (http://europa.eu.int/comm/health/ph_overview/pgm2007_2013_en.htm). Tighter regulation of provider services is also at the heart of health reform in all European countries (Allsop and Saks 2002; Blank and Burau 2004; Kuhlmann 2006a). Both are elements of new forms of governance that aim to produce new practices of welfare consumption and to challenge the scientific-bureaucratic power of welfare professionals. Such practices are also oriented to enabling consumers to play a more significant role as stakeholders in health care, exerting influence through a range of consultative and participative initiatives.

Although consumerism as a discourse operates at a trans-national level, most of the literature addresses developments in the Anglo-American health systems (e.g. Baggott et al. 2005; Davies et al. 2005; Lupton 1997; Peterson and Henderson 2002). Our intension in this paper, however, is to assess how such ideas are translated and enacted in specific national contexts. We set the apparently trans-European trend towards consumerism in health care in the context of more detailed study of its place in the modernisation of health systems in Britain and Germany. The paper addresses three questions:

- How do the politico-cultural and institutional characteristics of different nation states shape the meanings and practices of consumerism? Here we do not attempt to assess institutional divergence or convergence but to highlight ways in which consumerism, refracted through specific governmental projects, may present new dynamics which are likely to influence future trajectories of reform.

- How does consumerism shift the relationship between the state, the professions and the public? The constitution of newly authorised actors beyond the state, while investing them with new forms of political and economic power, cannot, we argue, be understood in terms of a simple dismantling or dis-aggregation of state power. Rather, we set out to conceptualise new flows and relation ships of power as consumers present new demands to professionals at the same time as states introduce new strategies of professional regulation.

- What might be the implications for an understanding of the centrality if private authority and responsibility as new strategies of governance? Here we look at the kinds of subjects constituted in consumer oriented governmental strategies in each country, noting their multiplicity and heterogeneity. This has implications for ways in which con-

sumers – in their different instantiations – can be said to enter the political stage, and for the extent of the symbolic, deliberative and choice making powers with which they are invested.

The paper draws on research in Germany and in England and Wales by each of the authors, but does not set out to be a comparative project. Rather, we look across both countries to suggest ways in which regulation interacts with consumerism in the modernisation of welfare governance, while drawing attention to the specific dynamics of change within each country. Britan and Germany have been selected because of the ways in which they exemplify different welfare regimes (state centric versus corporatised) and different kinds of 'settlement' between the medical professions and the state. We set this out in more detail in section 1, below.

1. The dynamics of welfare governance reform: consumerism in Britain and Germany

The appeal of consumerism derives from its ability to serve different interests and to connect economic benefits and social participation (Du Gay and Salaman 1992). The development of consumerist discourse can be linked to processes of individualisation and the construction of an 'autonomous-self' and 'reflexive actor' dominant in western societies (Giddens et al. 1994; Lupton 1997). These developments are related to a shift in the concept of citizenship that "represents a change in the organising principle of state welfare" rather than a retreat from the welfare state (Higgs 1998: 188). However, the relationship between economic and citizenship goals has always been ambivalent and a source of ongoing tensions. Such tensions are replicated in strategies for the modernisation of health services. Modernisation strategies collapse a number of different aspirations. One is concerned with the improvement of consumer participation in decision-making in order to respond to citizens' claims of self-determination and social inclusion. Another seeks to overcome the 'producer dominance' of health care systems by challenging professional power. A third encourages patients to take more responsibility for their own health and well being, both to reduce their reliance on state services and to promote better health outcomes. These different aspirations transform the figure of the dependent patient into the 'empowered user', the 'expert patient' and the 'discriminating customer' (Newman and Vidler 2005a and b). The constitution of these new subjects is accompanied by attempts to create professionals more accountable to the public (Allsop and Saks 2002; Clarke et al. 2005). This is to be achieved through a number of governmental policies and manage-

ment practices: the creation of new regulatory bodies, the setting of standards and use of performance indicators, the proliferation of inspection, audit and evaluation, and the turn to evidence-based medicine and decision-making (Gray and Harrison 2004).

Tensions between these different goals and aspirations can be traced in each of our case study countries, but are shaped by national politico-cultural and institutional contexts. Here we focus on developments in Britain (or more precisely England and Wales[1]) and Germany: two countries that serve as archetypes of different health systems that are often chosen for comparison. Britain represents a state-centred, centralised system of a National Health Service (Beveridge model), and Germany a corporatist, decentralised system with the oldest tradition of compulsory social health insurance (Bismarckian model). With respect to consumerism, however, we are more interested in the similarities. How do health systems that are not based on market laws respond to the demands on citizenship rights and 'choice' of the service users? Historically, both systems were established in order to reduce the social inequalities of market forces; the common goals were to improve the health of the population by providing access to good health services for all citizens. As market power does not provide a legitimating basis for decision-making in health care, in both countries there was a need to develop models of representing and negotiating the 'public interest' (Saks 1995) in the provision of and access to health care against the interest-based strategies of the professions, particularly medicine. As such Britain and Germany provide interesting case studies that illuminate different patterns of constructing 'a consuming public' (Petersen and Henderson 2002) and different dynamics at stake in attempts to regulate the health professions.

Table 1: Governance and consumerism in Britain and Germany

Britain	Germany
Tax funded with limited private provision	Social Health Insurance (SHI) system, mainly funded through employers and employees
Governance through the state and subordi-	Governance through a network of public

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[1] 'Britain' is problematic because of the devolution of health powers – in different ways and to different extents – to Scotland and Wales in the 1990s. Scotland now has powers to shape its own health policies, and Wales to adapt Westminster initiated reforms. We have continued to refer to Britain when discussing traditional institutional forms, but use 'England and Wales' to describe more recent reforms, despite the problems of collapsing these in ways that may not always be appropriate.

nate tiers of governance and regulation	law institutions with physicians' associations and SHI funds as key stakeholders
User participation in governance structures; patient and public involvement; more active role in decision-making on health treatments	User participation through "delegation" to SHI funds, recently complemented through stakeholder involvement of patient representatives
Traditionally a gate keeper system with limited choice of provider; moving towards greater emphasis on choice	Traditionally based on freedom to choose a provider; some current moves to constrain this freedom
Consumer-centred policy discourse	Patient-centred policy discourse

The health care systems of both Britain and Germany have been well described elsewhere (e.g. Allen and Riemer Hommel, 2005; Blank and Burau 2004; Baeringhausen and Sauerborn 2002; Busse and Schlette 2004; Ham 1997; Ham 2004; Moran 1999). At first sight there seem to be remarkable similarities in the policy aims and institutional reforms in each country. A common feature has been the move towards marketisation and managerialism from the 1990s onwards, underpinned by an attempted shift from supply to demand led health systems. Both have introduced institutional reforms oriented to the improvement of preventive care, the introduction of quality programmes and the standardisation of care, and greater co-ordination of provider services. However there are also important differences that derive from different legal, institutional and funding bases for health care. In Germany, the state has established a complex system of public law institutions that govern the provision of health care (Moran 1999). This sytem is based on two pillars: the self-administered and self-regulated physicians' associations and Social Health Insurance (SHI) funds. The provider side is repereented by physicians and the user side by the SHI funds. Although the main regulatory bodies have recently been expanded, and user representatives are now included, the legacy of the Bismarckian system based on two pillars lingers. The medical profession and SHI funds serve as mediators between the interests of state and citizen, managing the tensions that arise between them. In contrast to the federal system of Germany, the British National Health Service (NHS) is tax funded and has traditionally been based on high levels of centralised planning in order to ensure the principle of universal, free access to treatment for all citizens. However the statement 'tax funded' ignores the fact that the NHS has always been supplemented with private insurance models and with private hospitals. In Germany, about ten per cent of the population – who belong to the group of peak earners – are privately insured as membership in the SHI

system is not mandatory. Since the 1996 reform acts various forms of co-payment with patients have been introduced, and reinforced with the 2004 Health Modernisation Act (Kuhlmann 2006). Accordingly, both health systems make use of a mix of funding resources and provide various options to either limit or expand these additional financial resources. From its inception the NHS has been characterised by ongoing power struggles between the medical professions and successive governments, while governments in Germany – whether Christian Democratic or Social Democratic – have attempted to pass over the responsibility for negotiations and control to the public law institutions, based on the two pillars of SHI funds and physicians' associations. This corporatist system has the capacity to reduce social conflict, but also brings extra costs.

The coporatist regime means that political change in Germany has a less signficant impact on the health system than in Britain. In both countries social democratic or Labour governments came into force at the end the 1990s, in Britain the New Labour government and in Germany the Schröder government. In Britain policies were designed to secure the support of the middle class electorate on whom Blair's success had been based; as a result public service improvement was high on the agenda. However the different political climate in Germany meant that cost containment, rather than public service improvement, was a key driver of reform. Due to the coupling of SHI funding and the employment market, high rates of unemployment together with an aging population lead to a sinking basis of SHI funding. Consequently, managing the economic problems came to the top of the political agenda, with improving the quality of care a more marginal concern. The higher density of physicians and better accessibility of services in Germany than in Britain – e.g. short, if any waiting lists, and free choice of providers (European Observatory 2000) – meant that cost-containment and stability of insurance contributions were more likely to attract a a middle-calss electorate than improved user participation.

Other differences derive in part from the different institutional bases for health care in each country. In England and Wales there has been substantive institutional and organisational changes to the health care system, with the merger of providers into networks controlled by NHS managers (Fulop et al. 2005), new regulatory bodies for health professions allied to medicine (Allsop and Jones 2006), and a primary care approach that includes various professional groups and enhances changes in the health workforce (Davies 2003; Peckham and Ex-

worthy 2003). In contrast, in Germany the merging of providers remains in the hands of the medical profession, and the health occupations and professions are not included in the main regulatory bodies. In its German version, integrative care and co-ordination are for the main part reduced to models that aim to strengthen the position of office-based generalists and improve co-operation and co-ordination within the medical profession (Kuhlmann 2006; see SVR 2003; 2005); the introduction of disease management programmes for the chronically ill are one example of the impact of this approach (Pfaff et al. 2003). In Britain much attention was paid, in the 1990s, to better integration of primary care services (Peckham and Exworthy 2003), but this was accompanied by greater fragmentation and more competition between providers, not least because of the changing balance between public and private sector health providers. Most importantly, however, in Britain it is health managers as well as regulatory bodies that mediate between government and the public, making the difficult resource decisions; while in Germany, it is the SHI funds – together with the medical profession – that tend to play this role)although the SHI funds do not have the same power as the NHS managers in the negotiation processes). Accordingly, in Britain the inclusion of service users in as both consumers and stakeholders into new forms of governance arrangement acts as a buffer between government and public in Britain, while this possibility is less evident in Germany.

Consumerism in Britain and Germany

Stronger consumer involvement in the health policy process has been a policy aim in both countries over the last decade or more (Baggott et al. 2005; Davies et al. 2005; Department of Health 2005; NHS 1999; SVR 2003; 2005). Nevertheless important differences in its meaning and practice derive from the different institutional and political contexts noted above. In particular, structural incentives for improving user participation and choice are lower in Germany than in Britain. However such incentives are superimposed on very different traditions.

User participation is a relatively new policy issue in England and Wales, with a major impetus being provided under the policies of New Labour (Barnes, Newman and Sullivan, forthcoming), though the impact of user movements and self help groups under previous governments should not be underestimated – for instance, pressures for change arising from user demands on alternative and complementary medicine (Saks 1995; 2003), from the women's health movement, particularly related to maternity care, and the mental health movement (Baggott et

al. 2005). The corporatist system in Germany has, in contrast, a long tradition of stakeholder involvement. Due to the two pillars a need for negotiation and coordination of the interests of different stakeholders was embedded in the system; a network of public law institutions provided the arena for interactive planning and problem solving. In this arena – in the classical version of corporatist regulation – the SHI funds took on the role of representing the interests of service users, and this role was legitimated through democratic elections to their boards. In Britain Community Health Councils formed a similarly democratic, albeit institutionally weaker, means of representing the views of patients and stakeholders in the health system.

However in both countries the system was based on the *representation* of interests rather than an *active involvement* of users themselves. As we argue below, successive policy changes have aimed to introduce a more active role for consumers, clothing them with added authority in both the interactions between doctor and patient and in their participation in the governance of health services. In the reforms of the NHS in England and Wales Community Health Councils were abolished at the same time that a succession of initiatives to foster patient and public involvement were introduced; elections to the boards of the new Foundation Hospitals enabled some consumers to be directly involved in governance structures; and service providers were encouraged to both consult with and empower patients to a greater extent in the service encounter. And there have been a number of attempts to engage the public directly in the process of policy formation – for example through a series of Citizens Juries (Allsop and Jones 2006) . In Germany user representatives are also increasingly involved in policy-making but the 'voice' of these new stakeholders is weak. At present, the attempts to involve 'the public' is limited to some regulatory bodies and few user representatives: a point we expand on below.

The wheels turn? The dynamics of 'choice'

Despite an apparent convergence in the growth of consumer involvement and participation in both countries, a key difference lies in the political and cultural salience of 'choice' in the process of modernisation. The freedom to choose a provider has a long lasting tradition in Germany and is a highly priced value in society at large. Consequently, there is no comprehensive gate-keeper system (on the lines of the GP in Britain) that controls access to specialists care, nor the capacity to limit access to provider services through waiting lists and ration-

ing. Once again, the historically developed pattern of institutional regulation based on SHI funds and physicians' association is crucial to understand the different dynamics of 'choice' in our two case studies. The SHI funds have to balance their economic interests in controlling providers against their responsibility to represent the interests of a clientele who make strong claims for free choice of providers;

When it comes to recent changes and policy aims, however, the tradition of free provider choice in Germany and limited access in Britain is being overturned. In Germany, user 'choice' was extended in the 1990 reforms in the form of freedom to choose a SHI fund. However the tradition of free *provider* choice is viewed as driving up costs, because it encourages 'doctor hopping' and the extension of specialist care. Consequently, reforms increasingly aim to reduce the right to choose a provider by developing a gate-keeper system of general care providers ("*Hausaerzte*"). Since 2005 patients have to pay an – at present small – fee for every consultation of a specialists that is not recommended by a generalist. In the same vein, some sickness funds have introduced pilot projects where generalists act as gate-keepers (*Hausarztmodelle*); participation is, however, voluntary for both users and providers. These developments underscore the significance of economic forces as key policy driver in Germany that marginalise clientele-oriented strategies. However because of the importance of the politico-cultural values of free provider choice, the Social Democratic government has attempted to avoid conflict; new policies have sought to work indirectly by introducing a pattern of governing health care through financial incentives rather than the outright replacement of provider choice. Nevertheless, the aim is to reduce user choice and advance the standardisation of care by introducing a gate-keeper system and defining programmes of care.

In contrast, patient choice is now the centre-piece of government policy in England and Wales (Department of Health 2005). Here government expects service users to exercise a role as discriminating consumers and thus, it is hoped, shape the actions of physicians. The Secretary of State for Health has explicitly spoken of wanting to create instability in the institutional pattern of heath care by introducing consumer choice (interview cited in Guardian Society, 3/8/05 p 5), and the introduction of patient choice of provider, coupled with the principle that 'money will follow patients', opens up the possibility that some hospitals – or units within hospitals – may face closure if they are unable to attract sufficient 'customers'. The extent to which this possibility may be realised is still uncertain, not least because of oscillations in the

government's own agenda as it seeks to balance its determination to use service users as the new driver for reform on the one hand, and its fear of attracting criticism for unpopular outcomes of its policies on the other. Greener, tracing the evolution of 'choice' from the marketising reforms of the Thatcher administrations to the introduction of patient choice of a provider in certain conditions under New Labour, comments "the government appears to wish to pass responsibility for the running of health services to subsidiary organisations and individuals, while retaining strong central control." Having set up an NHS Inspectorate, and passed responsibility for driving reform through choice to patients, "the state has perhaps divorced itself from having to take any further blame for the health service's problems" (Greener 2003: 61).

It is clear that both governments face similar tensions as nation states engage in the modernisation of welfare governance in order to reduce spiralling costs and to address rising aspirations and new health needs. However as we have argued these are producing different dynamics. Most notable is the contrast between the extension of provider choice in England and Wales and attempts to reduce freedom of choice in Germany (see also Allen and Riemer Hommel 2006). This produces a marked difference in the political and policy discourses, with an emphasis on individualised patient care in Germany and a more explicit focus on consumerism and choice in England and Wales. We should not over-state this difference. Even in policy documents and political speeches emanating from Westminster and Whitehall, the discourse is rather more ambiguous: policy documents have a range of names for the consumer, frequently continuing to talk about them as patients. However these are different from the patients of the past – they are, in the words of the Patient Czar, the 'standing up' patients of the future rather than the 'lying down' patients of the past (Cayton, 2003). In both countries, then, we can trace a major impetus to reduce or curb the power of the health professions – an issues to which we turn in the following section.

2. Governance and the challenge to professional power

The different dynamics of institutional reform noted in section 1 produce new kinds of reconfiguration in the relationship between the state, the professions and the public (table 2). Here we set out to conceptualise new flows and relation ships of power as consumers present new

demands to professionals at the same time as states introduce new strategies of professional regulation.

Table 2: Different orientations towards the professions

England and Wales	Germany
Plural polity with proliferation new , quasi-state regulatory bodies and new forms of stakeholder involvement in decision-making	Corporatist system with long established but limited stakeholder arrangement, recently extended but not replaced
Challenge to professional power through 'empowered' and participating consumers	Challenge to professional power is more buffered through the system of delegation of user interests to SHI funds and the need to negotiate decisions with Physicians' AssociationsEllen – but presumably also challenge to professional power through 'empowered' and participating users as in UK?
Choice is used to counter producer power and introduce change in the system of care	Choice is in part compatible with producer power and a physician-centred system of care

Professional regulation and accountability in a plural polity

In Germany the SHI funds act as counterparts to the physicians' association in the regulatory arrangements. In England and Wales there has been a drive towards increasing professional regulation, not only of physicians but also of allied health professions and alternative and complementary therapists (Davies 2003; Saks 2003), groups that in Germany are denied professional status and excluded from the main regulatory bodies (European Observatory 2000). In Germany, patients are included as new actors in the system of care without substantively changing the regulatory patterns based on physicians' associations and SHI funds. The idea of consumers taking on a direct role in controlling providers is less evident than in the UK given the centrality of the physicians' associations and SHI funds. Consequently, the establishment

of independent consumer organisations is weak and service users tend to be viewed as 'second-class stakeholders'.

Differences in the regulatory systems and political cultures produce different orientations towards the professions. Although medical power is strong in Britain, the growth of a 'plural polity' within the health system opens out more possibilities of negotiation around the provision and use of information. Here there have been a number of systematic attempts to survey the views of patients and to take more account of patient experience in designing services, both in policy initiatives and also on the part of specific organisations. This has resulted in a number of initiatives to improve access and enhance patient experience (e.g. through 'one stop' treatment centres). In Germany new regulatory models like the disease management programmes have had a positive impact on user participation; such models have extended the reach of regulatory bodies and improved patient information. But such developments tend to be viewed with suspicion. Patients feel themselves to be 'objects' rather than actors in the emerging health care system (Kuhlmann 2006a).

The improvement of consumer participation is closely related to the debates on quality and public accountability in both countries. One central change in Germany has been the establishment of a national Institute of Quality and Efficiency in Health Care – notably, headed by a physician and funded by the SHI system. This signifies a new pattern of institutional control beyond the classical corporatist arrangement. In the same vein, the Federal Ministry of Health introduced in 2004 the office of Patient Representative in the federal government, paralleling the Patient Czar in the UK. Furthermore, user representatives are now participating in the negotiations of disease management programmes; these programmes mark the most important step of tighter organisation of ambulatory care and indicate a new willingness on the part of government to target health care (Kuhlmann 2006a). The involvement of consumer organisations in the health policy process had already been under negotiation in earlier reforms; since 2001 a pilot project funded by the Federal Ministry of Health has sought to promote shared decision-making and to improve communication between patients and providers. Almost all sickness funds have improved the provision of patient information, and some introduced new forms of access such as call centres (Wöllenstein 2004); however, there are no public controls or standards that regulate the quality of the information provided. Although recent changes in public institutions and the legal framework of health care mark an important step in Ger-

many's health policy towards improved citizenship rights and extended stakeholder regulation, they have not replaced the monolith of physicians' associations and SHI funds nor undermine the classic corporatist delegation of responsibility to these institutions.

While corporatism remains the dominant institutional framing in Germany, in England and Wales there has been a shift to a more plural polity alongside new forms of stakeholder involvement in decision-making bodies. For instance, Allsop and Jones found in a study carried out for the Council of Healthcare Regulatory Excellence "that the General Medical Council (GMC) and other professional councils have been increasing the numbers of of lay members on their boards and sub-committees as a matter of policy" (2006: forthcoming). According to this study the GMC has 40 per cent of lay members, and the Health Professions Council and the Nursing and Midwifery Council even 48 per cent. The authors conclude, "in terms of governance, councils have become smaller, and they contain a larger proportion of lay people as well as elected or appointed professionals" (Allsop and Jones 2006: forthcoming). The new Foundation Hospitals – institutions with considerably more delegated power than has been the norm in what otherwise remains a highly centralised system – are required to include elected lay representatives on their governing bodies. A further example is the National Institute for Health and Clinical Excellence that has strong stakeholder involvement (Davies et al. 2005). We can also observe new policies that aim to complement the gate-keeper system and centralised planning with new opportunities for both providers and the users, but also the withdrawal of older – and perhaps more democratic – structures. The directly elected Community Health Councils were replaced by a network of patient forums linked to each NHS and Primary Care Trust, co-ordinated by a Commission for Patient and Public Involvement in health care. These in turn have been reconfigured so that the role of those linked to Primary Care Trusts will be narrowed to consultation on service delivery rather than taking 'a wider public role in health related decision-making' (Sharon Grant, chair of CPPI, Society Guardian 23-03-05: 6).

These challenges to professional power 'from above' have, in each country, been accompanied by challenges 'from below' as patients are given access to – or seek out – new forms of information that enable them, in principle, to challenge the authority of clinicians. Some similarities in the ways in which user involvement is being enhanced can be traced across our two case study countries. Both have a concern with providing more information, and with empowering the voice of the service user Emphasis in each is placed on self-determined decision-

making and patient responsibility for their own health. Consequently, enhanced access to information is viewed as enabling users to exercise their new role as expert patients and discriminating consumers. Allen and Riemer Hommel (2006) observed "a degree of convergence" (2006: 202) between Germany and Britain on this issue but also noted persisting differences that mean that the provisdion of information to patients has been less successful in Germany. In England and Wales information is provided through self help and patient advocacy groups, through the promotional activities of Public Health services, and through schemes such as the 'expert patient' initiative. A call centre service – NHS Direct – provides information and advice to callers about how to deal with health issues and problems in the home and when to call on other medical services. However the quality and type of information is not always what patients most want. A recent study indicates that "NHS Direct facilitates patient empowerment in terms of helping people to be in control of their health and health care interactions" (O'Cathain et al. 2005: 1761), though it tends to be viewed with some circumspection by patients – unsurprising given that a primary goal of the service was to reduce pressure on GP surgeries and Accident and Emergency clinics. In Germany, the newly established Institute of Quality and Efficiency in Health Care will take over the role of providing safe and 'objective' information for the public. However it is headed by physician and funded by the SHI system, and user representatives and lay publics are not involved in the process of defining what is 'objective' information and which themes are of 'public interest'. It remains to be seen how the users respond to this new source of information; conflict of interest may arise from a model of 'producing' knowledge and information without including user perspectives.In both countries, then, the continued power of the medical profession to define knowledge and to mediate access to appropriate forms of information can be viewed as a means of delimiting consumer power, modifying governance reforms that seek to bestow new forms of authority and responsibility on welfare subjects.

Contesting the meaning of 'choice'

Despite the similarity of the consumerist discourse, different national contexts produce different approaches to reforming welfare governance by attempting to change the balance of power between consumers and producers. We noted in Section 1 how choice of provider is a central plank of the reform agenda in England and Wales, introduced with the explicit goal of challenging 'producer power'; while choice of provider in Germany has existed in a rather differ-

ent context, with little substantive impact on provider competition. Consequently, patients in Germany perceive choice as a-taken-for-granted right and tend to view recent policy aims can be viewed as a significant attack on such rights. In Germany, recent research suggests that that consumers may well contest the reforms by developing tactics to outflank the circumscription of their rights. Kuhlmann (2006a) reports that some research subjects indicated that that they would continue to contact a specialist directly where they perceived that the generalist was not competent to deal with their health need; others rejected the idea of being directed to the hospital responsible for the region in which they live; instead they continued to contact the hospital of their choice, negotiating with the physician for permission to be exceptionally treated there, despite the fact that this caused higher expenditures for the SHI fund. German respondents were shown to be seeking to defend their freedom to choose a provider and a treatment or diagnostic procedure as an important condition of self-determination and participation. Rather than challenging professional power, we can, then, see new points of alliance – or even complicity – between patients and clinicians.

In England and Wales choice was introduced by the New Labour government as a direct challenge to professional power, with the discourse constructing powerful oppositions between producer and consumer interests and setting out how the reform process is intended to challenge 'producer dominance', associated with the paternalism and 'one size fits all' culture of the past (Clarke and Newman, forthcoming). However research on the changing relationships produced by the new consumerist orientations suggests that professionals are well able to rework the meaning of choice to produce a tighter reconciliation with professional interests and orientations. In the process of institutional adaptation, professionals were re-describing choice within a vocabulary of partnership, enrolling patients as informed, reflexive health subjects able to participate in choice of treatment in order to secure better health outcomes (Newman and Vidler 2006a). The same research also found that patients were more than willing to engage in ideas of partnership. Respondents were keen to have more choice, but here choice acted as a condensate for a range of aspirations and desires, of which choice of provider tended to be a subordinate value (Clarke and Newman, forthcoming). The government discourse of choice – where the possibilities of patient choice of provider are viewed as delivering change in the health care system from the bottom up – tended to be rejected in favour of a more equal partnership between patient and doctor. The same research suggests the strength of

citizen, rather than consumer, identifications with the NHS, a feature of the politico-cultural context of the British health system (Newman and Vidler 2006b).

We can conclude that 'choice' is a host for different, and even contradictory, meanings and interests in both countries, producing different dynamics on the reconfiguration of professional power. One result is that the classic distinction between corporatist and state-centred health systems is no longer sustainable. In Britain there has been some move away from a centralised, uniform national service with more power being delegated to health providers, albeit with tight regulatory controls; while in Germany the recent health reforms suggest an increased willingness on the part of the government to regulate and to intervene, not least since research in Germany suggests that where consumers are dissatisfied with health policy they tend to direct their claims for improved choice to the government rather than to clinicians (Kuhlmann 2006a).
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We need, then, to go beyond simplistic formulations about information, choice or stakeholder involvement as a challenge to professional power, looking in more detail at the dynamics produced in different trajectories of reform. It is one thing to highlight the emergence of new discourses and new governmental strategies of reform; we need also to pose the question of how these discourses and strategies are being played out. How far do they suggest a destabilisation of professional power? Or is such power simply being reconfigured as a result of professional strategies? And how far might such new producer/user dynamics produce different trajectories of change in each country, despite superficial similarities?.

3. Professional mediation and appropriation: challenges to the authority of the consumer

Sections 1 and 2 of this paper outlined ways in which, while in both England and Wales and in Germany, new relationships of authority, responsibility and choice are being shaped in the reconfiguration of professional and state powers and the investment of the health consumer with new forms of authority. We have highlighted ways in which these processes of reconfiguration are taking different forms, in part because of the different institutional histories and politico-cultural contexts of our two case study countries. Here we draw out some of the im-

plications for understanding the consumer as both the object of, and agent in, the modernisation of welfare governance.

The reforms highlighted above suggest not a singular, neo-liberal instantiation of the 'market savvy' consumer, but her enrolment into different political projects and strategies. [S]he may be enrolled in the project of destabilising state-centric models of health care delivery by making choices between provider; as an informed, empowered service user able to challenge professional authority; as a 'partner' with health providers in modernised models of health care; as 'an expert' in their own condition; as a reflexive subject able to take more responsibility for her own health and well being, thereby reducing – or at least changing the nature of – reliance on health systems and contributing to the social good of public health; as a citizen, contributing to democratic decision making and good governance; and as a newly empowered actor contributing to the regulation of the over-weaning power of the professions. The balance between these instantiations shifts over time, and is elaborated in different ways in our two case study countries. But in each we can see ways in which the authority of the consumer is both being augmented, and enrolled in the development of new forms of welfare governance.

But this authority is not unproblematic. Health professions have an ambiguous role in the reform process: they may be viewed as a source of resistance; but they also serve as a 'buffer' between diverse and conflicting interests (Stacey 1992). Rather than resister or buffer, however, we want to highlight their role in mediating the power of the consumer, channelling it into 'responsible' directions by promoting the concept of the reflexive, informed and participating welfare subject. This is empowerment – but the power with which the consumer is invested is highly conditional, slipping into the possibility of its obverse – the nuisance patient, the litigious customer, the 'difficult' service user, the consumer who 'knows too much for his own good' and therefore places 'unreasonable' demands on the health system. Our argument here echoes a number of studies from different countries (e.g. Gabe and Calnan 2000; Lee and Garvin 2003; Lupton 1997; Sullivan 2003); it confirms the limitations of a model of market savvy and reflexive actors keen to search the Internet and other resources in order to make 'rational' decisions and to discriminate between health care providers.

Research by the authors in each country suggests ways in which new discourses can be deployed by different actors and transformed in line with their interests; and professional power

plays a pivotal role in that process. In both countries physicians have developed strong mechanisms to resist and redefine the idea of consumer power. Professional strategies have been remodelled in order to meet the new requirements for empowered patients and accountability (Allsop and Saks 2002; Kuhlmann 2006). However the same research has also suggested ways in which consumerism may be a discourse that provides opportunities for professionals and consumers to form new kinds of alliance. Such alliances produce new instabilities in the system of health care, undercutting the free flow of market mechanisms and resisting some governmental strategies of reform. The alliances between users and providers may at present be stronger in Germany than in Britain, and the room for manoeuvre on the part of physicians greater. But in both countries we can trace ways in which consumers may be drawn by professionals into notions of partnership with service providers. This opens out the possibility of the enrolment of patients – as 'experts' in their own condition – into bio-medical forms of power controlled by clinicians.

For example the complexity of 'choice' from the perspective of patients furnishes the medical profession with new opportunities to translate a discourse of consumerism into a professional discourse of patient-centred care and empowerment. These developments are already visible. Rather than simply resisting change health professionals often draw on elements of the consumerist discourse to discuss how to deliver better health outcomes for patients (Newman and Vidler 2006a). And in Germany we have seen (section 1, above) patients forming alliances with physicians to counteract health policy aims; the system provides opportunities for both users and providers to bypass or outflank tighter regulation. Patients take up their new role as discriminating consumers, but in ways that depart from the intentions of government.

The authority of the consumer in neo-liberal governance is then both constrained and delimited by professional power. Professionals struggle to sustain the hegemony of biomedical over 'lay' knowledge, and to deflect new state policies on choice around their own – and their patient's – interests (though the form this takes differs markedly in the two case study countries). However we also want to highlight the *new configurations of power* as complex and multifaceted, rather than viewing professional and consumer power in terms of a zero-sum game, in which for the power of the consumer to be enhanced that of the professional must be challenged.

Our analysis challenge assumptions about the existence of fundamental conflicts between the interests of users and providers of health care. In both countries user power is limited, and in both the medical profession is attempting to transform user participation into patient-centred care. In Germany, however, consumer power may present more of a challenge to the state than to the professions, while in Britain the potential for such challenge is buffered by a plural polity of actors and greater delegation to quasi-autonomous bodies. While we have not attempted a systematic comparison, we have suggested ways in which the concept of consumerism based on market savvy actors or empowered service users is limited in both states. New forms of welfare governance - including regulation, choice and participation - may nurture dissatisfaction with government but do not necessarily lead to a decline of trust in doctors (Calnan and Sandford 2004; Kuhlmann 2006b). Health policy, then, does not cope successfully with 'the spirits it has summoned', i.e., citizen consumers and expert patients who are bold and savvy enough to claim their rights.

However the health consumer is not a singular welfare subject but condenses a host of different identities, each invested with distinct forms of power. Here we want to distinguish between their symbolic power (representing new forms of authority in neo-liberal welfare governance, associated with the individualism and reflexivity of late modernity); their deliberative power (suggesting new forms of engagement in a plural polity alongside the collapse of older democratic forms); and their choice making power. This latter is of particular interest, implying, in the new instantiation of the citizen-consumer, some funamental shift in the nature of citizenship itself (Clarke et al forthcomong). Consumers, then, might be said to be entering the political stage – but the stage is no longer a national stage and the roles they are offered have scripts that are highly edited by institutional, professional and state powers.

Conclusion

This paper has set out to explore the dynamics of consumerism in Britain and Germany. In doing so it has stressed the need to transcend a global language of modernisation in order to uncover context specific dynamics flowing from the politico-cultural and institutional features of specific nation states. We have also suggested ways in which the dynamics of the systems regulating health care providers are not only different, but produce different points of instabil-

ity. In Britain the state has set itself up as a champion of consumers, and has demonstrated a new willingness to improve choice and access to information; while in Germany the Social Democratic government has attempted to circumscribe choice and has taken a weaker role in terms of ensuring greater transparency of services and enhanced access to information, despite user demands that it should act more strongly on their behalf. In Germany it is evident that the government cannot rely on patients as partners to control health care providers. Efforts to introduce new models of care tend to be viewed with suspicion, and are overshadowed by patient concerns. As such, in Germany consumerism may be more a challenge to the state than to the professions. In Britain any challenge to state power is buffered by greater delegation to quasi-autonomous bodies (regulatory agencies, foundation hospitals, etc) and by the wider range of professional groups that have been drawn into the regulatory process.

In each country, as we have argued, complex tensions are played out in the changing relationship between users, professionals and the state. A challenge for researchers is to unpack the relationship between global models and national conditions, and to explore the interface between discourse, agency and institutional change. The move towards a consuming public and accountable professionals impacts on the relationship between the state, the public and the health professions but in ways that cannot be captured by existing typologies of welfare states, nor by theories of European convergence. We have deliberately not dealt with EU policy and its impact in this paper; what we are interested in is the way in which new European policy discourses of the health consumer become interpreted and enacted in different contexts.

Consumers may act in ways not intended and not fully under the control of governments in both countries. We cannot, then, understand the dynamics of consumerism as simply a product of different institutional forms (path dependency) because in both countries it enhances uncertainty. Consumerism not only challenges medical power and knowledge; it also challenges and changes the concepts of both state and public. In doing so, it creates new instabilities in the governance of health care. Particular elements of professional self-regulation and corporatism are important in all health care systems, however state-centred or market driven they may be. Accordingly, the state, the professions and the public are connected in more complex ways and change in one relationship creates dynamics that may impact on other relations. The effects may be unintended, uneven and even contradictory.

References

Allen, P. and Riemer Hommel, P. (2006). What are 'third way' governments learning? Health care consumers and quality in England and Germany. *Health Policy* 76: 202-213.

Allsop, J. and Saks, M. (eds.) (2002) *Regulating the Health Professions*. London: Sage.

Allsop, J. and Jones, K. (2006) The regulation of health care professions: Towards greater partnership between the state, professions and citizens in the UK. *Knowledge, Work & Society* 4 (1): forthcoming.

Baggott, R., Allsop, J. and Jones, K. (2005) *Speaking for Patients and Carers. Health Consumer Groups and the Policy Process.* Basingstoke: Palgrave.

Bäringhausen, T. and Sauerborn, R. (2002) One hundred and eighteen years of the German Health Insurance System. *Social Science and Medicine* 54: 1559-1587.

Barnes, M, Newman J and Sullivan, H (forthcoming, 2006) *Power, participation and political renewal*. Bristol, Policy Press.

Blank, R. H. and Burau, V. (2004) *Comparative Health Policy*. Houndmills: Palgrave.

Busse, R. and Schlette, S. (eds) (2004) *Gesundheitspolitik in Industrieländern.* Gütersloh: Bertelsmann.

Calnan, M.W. and Sanford, E. (2004) Public trust in health care: The system or the doctor? *Quality and Safety in Health Care* 13: 92-7.

Clarke, J. and Newman, J. (forthcoming) 'What's in name? New Labour citizen-consumers and the remaking of public services.' *Cultural Studies*.

Clarke, J., Smith, N. and Vidler, E. (2005) Consumerism and the reform of public services: inequalities and instabilities. In Powell, M., Clarke, K. and Bauld, L. (eds.). *Social Policy Review* 17: 167-182.

Clarke, J, Newman, J, Smith, V, Vidler, E and Westmarland, L (forthcoming) *Creating citizen-consumers: changing publics, changing public services,* London, Sage.

Cayton, H. (2003) *Trust Me, I'm A Patient: Can Healthcare Afford the Informed Consumer?*, Speech Delivered to the Royal College of Physicians, BUPA Health Debate, 2nd September 2003, London.

Coulter, A and Magee, H (2003) *The European Patient of the Future*. Picker Institute Europe. Buckingham, Open University Press.

Davies, C. (ed.) (2003) *The Future Health Workforce*. Houndmills: Palgrave.

Davies, C., Wetherell, M., Barnett, E. and Seymour-Smith, S. (2005) *Opening the Box: Evaluating the Citizen Council of NICE.* The Open University, Report Prepared for the National Co-ordinating Centre for Research Methodology, NHS Research and Development Programme.

Department of Health (2005). Creating a patient led NHS: Delivering the NHS improvement plan. London: Department of Health

DuGay, P. and Salaman, G. (1992) The cult(ure) of the customer. *Journal of Management Studies* 29 (5): 615-633

European Observatory on Health Care Systems (2000) *Health Care Systems in Transitions. Germany*. http://www.euro.who.int/document/e68952.pdf.

Fulop, N., Protopsalis, G., King, A., Allen, P., Hutchings, A. and Normand, C. (2005) Changing organisations: a study of the context and processes of mergers of health care providers in England. *Social Science and Medicine* 60: 119-130.

Gabe, J. and Calnan, M. (2000) Health care and consumption. In Williams, S., Gabe, J. and Calnan, M. (eds.). *Health, Medicine and* Society: *Key Theories, Future Agendas*. London: Routledge, 255-273.

Giddens, A., Beck, U. and Lash, S. (1994) *Reflexive Modernization*. Cambridge: Polity Press.

Gray, A. and Harrison, S. (eds.) (2004) *Governing Medicine. Theory and Practice*. Berkshire: Open University Press.

Greener, I. (2003) Who choosing what? The evolution and impact of 'choice' in the NHS, and its importance for New Labour. In Bochel, C., Ellison, N. and Powell, M. (eds.) *Social Policy Review* 15: 49-68.

Ham, C. (ed.) (1997) *Health Care Reform: Learning from International Experience*. Buckingham: Open University Press.

Ham, C. (2004) *Health Policy in Britain*: 5th edition. Basingstoke, Palgrave-Macmillan.

Harrison, S. (1998) The politics of evidence-based medicine in the United Kingdom. *Policy and Politics* 26 (1): 15-31.

Harrison, S. and Mort, M. (1998) Which champions, which people? Public and user involvement in health care as a technology of legitimation. *Social Policy and Administration* 32: 60-70.

Higgs, P. (1998) Risk, governmentality and the reconceptualization of citizenship. In Scambler, G. and Higgs, P. (eds.). *Modernity, Medicine and Health*. New York: Routledge, 186-197.

Kuhlmann, E. (2006a) Modernising health care. reinventing professions, the state and the public. Bristol: the Policy Press, forthcoming.

Kuhlmann, E. (2006b) Traces of doubt and sources of trust – Health professions in an uncertain society. In Evetts, J. (ed) Professions, trust and knowledge, *Current Sociology,* Monograph Series, forthcoming.

Lee, R. G. and Garvin, T. (2003) Moving from information transfer to information exchange. *Social Science and Medicine* 56: 449-464.

Lupton, D. (1997) Consumerism, reflexivity and the medical encounter. *Social Science and Medicine* 45: 373-381.

Moran, M. (1999) *Governing the Health Care State*. Manchester: Manchester University Press.

Newman, J. and Vidler, E. (2006a) Discriminating consumers, responsible patients, empowered users: consumerism and the modernisation of health care. *Journal of Social Policy*, forthcoming

Newman, J. and Vidler, E. (2006b) 'More than a matter of choice? Consumerism and the modernisation of health care.' In L. Bauld, K. Clarke and Maltby, T. (eds) *Social Policy Review 18.* Bristol, The Policy Press.

NHS – National Health Service Centre for Reviews and Dissemination (1999) Getting Evidence into Practice. *Effective Health Care*, 5 (1)

O'Cathain, A., Goode, J., Luff, D., Strangleman, T., Hanlon, G. and Greatbatch, D. (2005) Does NHS Direct empower patients? *Social Science and Medicine* 61: 1761-1771.

Peckham, S. and Exworthy, M. (2003) *Primary Care in the UK*. Basingstoke: Palgrave.

Petersen, A. and Henderson, S. (eds) *Consuming health: The commodification of health care.* London: Routledge.

Pfaff, H., Schrappe, M., Lauterbach, K. W., Engelmann, U. and Halber, M. (eds) (2003) *Gesundheitsversorgung und Disease Management*. Bern: Hans Huber.

Rose, N. (1999) *Powers of freedom.* Cambridge: Cambridge University Press.

Saks, M. (1995) *Professions and the public interest: Medical power, altruism and alternative medicine*. London: Routledge.

Saks, M. (2003) *Orthodox and Alternative Medicine. Politics, Professionalization and Health Care*. London: Sage.

Saks, M. and Kuhlmann, E. (2006) Introduction. Professions, social inclusion and citizenship: Challenge and change in European health systems. *Knowledge, Work & Society* 4 (1): forthcoming

Sullivan, M. (2003) The new subjective medicine: taking the patient's point of view on health care and health. *Social Science and Medicine* 56: 1595-1604.

Stacey, M. (1992) *Regulating British Medicine: The General Medical Council*. Chilester: Wiley.

SVR – Advisory Council for the Concerted Action in Health Care (2003) *Health Care Finance, User Orientation and Quality*. Report summary, English version. http://www.svr-gesundheit.org.

SVR – Sachverständigenrat im Gesundheitswesen (2005) *Koordination und Qualität im Gesundheitswesen*. Gutachten. http://www.svr-gesundheit.org.

Wöllenstein, H. (2004) Der informierte Patient aus Sicht der Gesetzlichen Krankenversicherung. *Bundesgesundheitsblatt* 47 (10): 941-949.