Personalisation in England’s National Health Service – Combining exit, voice and loyalty?

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Abstract

Different versions of choice are at work in the UK’s National Health Service (NHS). A hard version of choice associated with provider competition (and patient exit) appears to be giving way to a ‘softer’ concept of ‘personalisation’, emphasising choice and voice at the micro level, but also drawing on solidaristic themes. As personalisation becomes increasingly central to NHS reform, it is important to understand better the ways in which the personalisation narrative is being used and to trace its ambivalent relationship with exit, voice and loyalty. This paper uses a content analytic method to explore how personalisation has been positioned in ministerial speeches and health policy documents. It finds that personalisation is located in a discourse of organisational decline and disruption, emphasising the need for exit and voice, but also one of continuity, trust and equity, emphasising loyalty to shared welfare services. Hirschman (1970) makes clear that an interplay between exit, voice and loyalty is to be expected. However, there is an ambivalence in their relationship which is being ignored by health policy-makers. Frontline staff and service users will be left to negotiate an agenda which positions them as both partners and adversaries.

‘Choice’ has been a central tenet of reform in England’s National Health Service (NHS) for a decade (Greener, 2003; Fotaki, 2009; Greener and Mannion, 2009; Needham, 2008a). However, there are various different versions of choice at work, of which two broad categories stand out. There is the hard notion of choice, associated most strongly with the second half of the Blair premiership, where patients are given choices in competitive markets in order to incentivise service providers (Le Grand, 2007; Needham, 2007, 2008a). Choice here takes place at both the meso (choice of hospital) and micro levels (choice of treatment plan) (Greener, 2003). There is also a softer version of choice, linked to the notion of ‘personalisation’, in which patients receive a more tailored service,  

1 Following devolution reforms of the late 1990s, the health systems of Scotland, Wales and Northern Ireland, are increasingly diverging from the English model, such that ‘We basically have four different systems, albeit with the same set of values’ (Branigan and Carvel, 2008: 13). This paper focuses on the NHS in England only.
with emphasis on choice at the micro level (Public Administration Select Committee, 2005). In the hard version of choice, as expounded by Blair’s former health adviser Julian Le Grand, patients are given choices whether they want them or not, in order to discipline providers and improve services (Le Grand, 2006). In contrast, Gordon Brown (2007a) calls for a health service which is ‘personal to you’, equipping patients with ‘the choices that they themselves want to make’.

Personalisation is becoming a central theme in Labour’s health reforms (Darzi, 2007, 2008; DoH, 2009a). It has transferred from the social care sector, where a discourse of personalisation – linked primarily to the payment of budgets to people with disabilities – has taken a strong hold (DoH, 2007). In 2008 the government announced the extension of individual budgets into the National Health Service, to cover people with long-term health conditions (DoH, 2009a). Personalisation is also emerging as a central theme in education and social security (DfES, 2005; Gregg, 2008). Leadbeater calls personalisation ‘a new organizing logic for service provision…as influential as privatization was in the 1980s and 1990s in reshaping service provision’ (Leadbeater 1994: 19, 18). Beresford notes the momentum that has gathered behind the idea of personalisation, which has progressed from ‘little more than a vague idea in a 2005 Green Paper’ to an ‘unstoppable force’ (2008: 8).

The radical claims made for personalisation, and its rapid migration across public services make it essential to understand it better. Whilst the hard version of choice can be mapped onto Hirschman’s (1970) account of exit, personalisation is harder to categorise. As promoted by Labour ministers, personalisation presumes dialogue and negotiation with a health professional (voice) as part of a choice process which may lead to exit (Minister of State for the Department of Health, 2005; Darzi 2007, 2008). Yet the more ‘personal’ NHS is also one in which patients are expected to be more active (*more involved in their own health care* (Brown (2008a)), and in which the needs of disadvantaged service users will be prioritised (Darzi, 2008: 9). These elements of an NHS that is ‘personal to you’ (Brown, 2007a,b) appear to evoke co-productive and
solidaristic accounts of health care, which rely on a sense of what Hirschman calls ‘that special attachment to an organisation known as loyalty’ (1970: 77).

To explore this ambivalent relationship with exit, voice and loyalty, the paper uses a content analytic method, examining how personalisation has been used in ministerial speeches and health policy documents. It takes an interpretive approach, rejecting the search for an essentialist account of personalisation and focusing on understanding ‘the relevant meanings, the beliefs and preferences of the people involved’ (Bevir and Rhodes, 2003: 1). The policy process is understood as one of ‘meaning making’ (Lendvai and Stubbs, 2007: 174), and personalisation is approached as a narrative within it. Narratives ‘explain actions by reference to the beliefs and preferences of the relevant individuals ... [and] encompass the maps, questions, languages and historical stories...’ (Bevir and Rhodes, 2003, p. 26). A narrative has more specificity than analysis of discourse (Morrell, 2006, p. 372). It involves story-telling and internal logics: ‘We account for actions, practices and institutions by telling a story about how they came to be as they are and perhaps also about how they are preserved’ (Bevir and Rhodes, 2003, p. 20). Work has been done elsewhere to explore New Labour’s overarching narrative, positioning it within distinctive historical traditions (see for example Bevir, 2005). Here the focus is more narrowly on understanding the ways in which health policy texts use a personalisation narrative, although there may be a case for arguing that personalisation is becoming central to New Labour’s meta-narrative (Needham, forthcoming). Through analysis of health policy documents and ministerial speeches, the paper considers the extent to which personalisation is a coherent reform narrative, and how it intersects with choice, voice and solidaristic approaches to healthcare. The next section traces the emergence of personalisation as a key theme in healthcare, before going on to look at its meaning in more depth.
**Targets, Choice and Personalisation**

A commitment to personalisation in healthcare can be seen as the evolution, over thirty years, of the idea that services should be organized at the convenience of service users rather than providers (Needham, 2007: ch 4). Klein describes service users as the ‘ghosts in the machine’ of the original NHS, lacking any institutional voice to press their interests (Klein, 2001: 59). The practice of booking several patients for the same outpatient appointments, for example, ‘reflected the assumption that not a second of the consultant’s time must be wasted but that time spent by the patient waiting was of no account’ (Klein, 2001: 180). The Conservatives, in government from 1979 to 1997, introduced a ‘quasi-market’ into the NHS, but the reforms gave few new powers to the individual user beyond an expanded right to change their General Practitioner (GP) (Klein, 2001: 171; Le Grand and Bartlett, 1993: 2). During the early 1990s, John Major’s Patient’s Charter provided health service users with various explicit rights, ranging from the right to be treated on the basis of clinical need not ability to pay, to the right for outpatients to be given a specific appointment time and treated within 30 minutes (NHS, 1995). North talks of the ‘symbolic importance’ of the Charter in increasing patient expectations of the health service (North, 2001: 126).

Early in New Labour’s first term in office, Blair expressed his intention to tackle the ‘uniform, one size fits all’ welfare state (Blair, 1999). Although neat periodisations are problematic, a number of authors point to distinctive, if overlapping, reform imperatives during New Labour’s time in government (Needham, 2007, Greener, 2008, Paton, 2008; Bosanquet, 2008, Shaw, 2008). These have been evident across a range of public services, highlighting the government’s repeated attempts to develop a coherent public service narrative (Taylor, 2001; Miliband, 2006). Blair himself, in a 2003 speech, characterized New Labour’s reform phases as a first term focus on the development of centralised measures of inspection and accountability (1997-2001), and a second term drive to put more power in the hands of service users (after 2001). Even allowing for post-hoc rationalization, this version does appear to reflect the priorities for the
government in the two periods, although for the most part choice was layered on top of targets rather than replacing them.

The shift is exemplified in the attitudes of New Labour’s first two Secretaries of State for Health. Whereas Frank Dobson (who held the post from May 1997 to October 1999) described choice and diversity in the NHS as ‘silly’ (2003, interview with the author), Alan Milburn (Health Secretary from October 1999 to June 2003) stressed that ‘People demand services tailored to their individual needs. People want choice and expect quality’ (Milburn, 2003). Dobson’s time in charge saw an emphasis on patient responsibilities and needs rather than choices (Appleby et al., 2003: 12, DoH, 1998a: §1.4). Milburn’s period as Health Secretary (which coincided with increased investment in the NHS) saw the launch of pilot choice programmes, alongside a commitment to greater provider diversity (a Concordat with the private sector, and the creation of Foundation Hospitals) (Bosanquet, 2008: 388). Milburn’s successors John Reid (June 2003 to May 2005) and Patricia Hewitt (May 2005 to June 2007) continued with the choice oriented reforms. By 2006, choice of provider had been launched nationally under the NHS Choose and Book scheme, premised on a payment by results system (or, rather, payment by activity) to incentivise providers (DoH, 2002).

Just as choice of provider was added to a target-based approach, so now too it is possible to see a ‘personalisation’ agenda being layered on top of the provider choice imperative. Blair made a commitment at the end of 2004 ‘to change the National Health Service into a personalised health service for each individual’ (Blair, 2004a). Earlier waves of investment and reform were retrospectively positioned as having made the NHS ready for personalisation (DoH, 2004a: 42). The Expert Patient programme was introduced to enable patients with chronic conditions such as diabetes and asthma to make ‘micro’ as well as ‘meso’ level choices (Appleby et al., 2003: 10). In one of two recent reports commissioned by Brown into the future of the NHS, the health minister Lord Darzi argues that much of the personalisation agenda has been achieved already, through greater use of information technologies (including the online/telephone enquiry service NHS Direct and the Choose and Book system) and longer opening hours for GP
surgeries (Darzi, 2007: 12). The recent launch of a pilot scheme for personal budgets in the NHS has been the most explicit and high profile commitment to personalisation – although the government has been keen to emphasise that personalisation is about ‘care planning’ and ‘support for self-care’ as well as individual budgets (DoH, 2009a: 11, 8). The pilots are modelled on those being used in the social care sector, which enable people with long-term health conditions to ‘buy in’ their own package of services (Ellis, 2007; Carr, 2008: 6).

**Understanding Personalisation**

The emergence of personalisation as a distinctive theme of ‘late’ New Labour has wrong-footed government critics from both the left and right of the political spectrum. This is, in part, because its genus is more complex than target-based reforms (with their roots in performance management (Barber, 2007) and provider choice reforms (premised on neo-classical economic assumptions (Le Grand, 2007)). Within social care personalisation has been driven, to some extent, by service users, drawing on the social model of disability and the independent living movement (Carr, 2008: 10; Beresford, 2008). Yet it has also emerged from New Labour’s own search for a ‘third way’ in welfare reform. Ferguson notes that personalisation is entirely compatible with some of the ongoing themes of New Labour’s welfare reform programme: ‘individualization, responsibilization and the privatization of risk’ (Ferguson, 2007: 389). Cabinet member David Miliband has positioned personalisation in third way terms as ‘a model of public service delivery that overcomes the limitations of both paternalism and consumerism’ (2004: 11).

The ambivalence of personalisation is a recurrent theme in the literature (Leadbeater, 2004; Parker and Heapy, 2006; Ferguson, 2007; Beresford, 2008; Carr, 2008). Leadbeater describes personalisation as ‘a very potent but highly contested and ambiguous idea’ (2004: 18). He conceives it as a continuum, with a ‘shallow’ version at one end, which involves ‘modest modification of mass-produced, standardized services to
partially adapt them to user needs’ (2004: 20). He favours an approach called ‘deep personalisation’, or ‘personalisation through participation’, at the other end of the continuum, in which people ‘devise their own bottom-up solutions, which create the public good’ (2004: 26). Parker and Heapy (2006: 87) similarly see a possibility for personalisation to be about ‘co-design and co-creation’ (which they favour) or simply ‘mass customisation’. Beresford distinguishes between personalisation as new freedoms for supported service users (emerging from the independent living movement), or ‘a process of rebadging, where the language of consumerism and control does little more than overlay arrangements that remain essentially the same’ (2008: 11-12).

Much of the existing analysis draws on the social care sector, in which personalisation is further developed than in healthcare. Thus there is a challenge, both to try to make sense of this apparent ambivalence, and also to identity its distinctive positioning as it migrates into the NHS. Given that the personalisation agenda within the NHS is at a relatively early stage – with the pilot scheme for personal health budgets only announced in January 2009 – the focus here is not on the implementation or evaluation of personalisation but on considering its discursive positioning as a policy narrative.

A content analytic method is used to explore how a range of health policy texts contribute to an emerging narrative of personalisation. The set of documents analysed includes major health policy documents and ministerial speeches from the 1997 to 2008 period. Expert collections of New Labour policy were mined to identify the most regularly cited health policy documents (Powell 1999; Savage and Atkinson 2001; Ludlam and Smith 2004; Dorey 2005; Seldon and Kavanagh 2005, Seldon 2007, Powell 2008). Reference to a document in one or more collection was taken to indicate that it made an important contribution to policy in that area. The most recent relevant health policy documents were also included to ensure that the findings were up to date. All documents were downloaded from the Department of Health website. Speeches were taken from the online archives of 10 Downing Street, the Department of Health and the Labour Party. The sample includes all available speeches from New Labour’s Secretaries of State for Health and all Prime Ministerial speeches that made reference to health
policy (including annual party conference speeches). Although these texts do not share the same purpose or audience, they are all used to outline strategic approaches to the delivery of health services, and reveal some of the assumptions of policy actors about those services.

The content analysis was undertaken as a two-stage process, combining quantitative and qualitative approaches. First, keyword searches identified paragraphs in the speeches and policy documents which contained the terms ‘personalise’ and ‘personalisation’. Searches looked for the stem of the word allowing for a range of word endings and spellings (personali*). Keyword-in-context lists were used to eliminate irrelevant hits (such as personality). The searches generated quantitative data on the number of relevant uses of the terms. Paragraphs using the keywords were imported into NVIVO software for coding, using inductive analysis to examine how ministers and policy-makers were constructing particular types of meaning around ‘personalise’ and ‘personalisation’. Thematic codes included, for example, ‘personalisation as personal budgets’ and ‘personalisation as personal responsibility’. The author then read through the documents and speeches to assess how far the key themes were evident in passages where the search terms themselves were not used – for example, where synonyms such as tailored or individualised were utilised. This two-stage approach combined the advantages of quantitative analysis, generating reliable and comparable data on the uses of ‘personalise’ and ‘personalisation’, but ensures inclusion of sections of the documents in which personalisation themes were discussed without using that exact language, to enhance validity.

The Personalisation Narrative within the NHS

Content analysis of the health texts shows that personalisation becomes a key theme in NHS policy documents from around the middle of New Labour’s second term in office (the term lasted from 2001-2005), as shown in Table 1. Although the 2000 NHS Plan has three mentions of the need to ‘personalise’ services, it is later documents,
particularly the 2004 NHS Improvement Plan that more fully develop the notion (with 22 hits for ‘personalise’/‘personalisation’). Table 2 shows the use of personalisation in the speeches of New Labour’s Prime Ministers and the three most recent health secretaries (comprehensive, searchable speech data for Labour’s first two secretaries of state is not available). Although time series data is not presented here, analysis elsewhere shows that it is not until 2003 that Blair starts to talk of the need for public services to be ‘personalised’ (Needham, 2007). He returns to that language 11 times in subsequent speeches. Analyses of the health secretaries’ speeches since June 2003 show that all use the personalisation language, including Alan Johnson, who took up the post in mid-2007 when Brown became Prime Minister.

Brown himself does not talk of personalisation, nor is the language of personalisation used in the NHS Constitution, a guide to values, rights and responsibilities within the health service published by the government in January 2009. This finding challenges the notion that personalisation has become a dominant Brownite narrative within health. Brown’s favoured discursive framing appears to be an NHS that is ‘personal to you’ (Brown, 2007a). However, his diffidence about the language of personalisation has not restricted his support for policy mechanisms that drive it forward. Personal budgets, described as ‘a totemic Blairite policy’ (2008:17), and one pushed by ‘Blairites’ such as Alan Milburn (2007), were rejected in the NHS whilst Blair was Prime Minister (DoH, 2006: 85). It is under Brown that budgets are now being piloted (Paton, 2008: 17; Brown, 2008b). This may be part of a broader effort by Brown to avoid the discursive positionings of his predecessor, whilst developing policy initiatives which show broad continuity (Needham, 2008a).
Table 1: Frequency of usage of personalise/personalisation in NHS Policy Documents, 1997-2009

<table>
<thead>
<tr>
<th>NHS Policy Documents</th>
<th>Year</th>
<th>Personalise/personalisation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The New NHS - Modern and Dependable</td>
<td>1998</td>
<td>0</td>
</tr>
<tr>
<td>Saving Lives: Our Healthier Nation</td>
<td>1999</td>
<td>0</td>
</tr>
<tr>
<td>The NHS Plan: A Plan for Investment, A Plan for Reform</td>
<td>2000</td>
<td>3</td>
</tr>
<tr>
<td>Delivering the NHS Plan: next steps on investment, next steps on reform</td>
<td>2002</td>
<td>0</td>
</tr>
<tr>
<td>The NHS Improvement Plan: Putting People at the Heart of Public Services</td>
<td>2004</td>
<td>22</td>
</tr>
<tr>
<td>Choosing Health</td>
<td>2004</td>
<td>15</td>
</tr>
<tr>
<td>Our Health, Our Care, Our Say</td>
<td>2006</td>
<td>12</td>
</tr>
<tr>
<td>High Quality Care For All, NHS Next Stage Review: Final Report</td>
<td>2008</td>
<td>16</td>
</tr>
<tr>
<td>NHS Constitution for England</td>
<td>2009</td>
<td>0</td>
</tr>
<tr>
<td>Personal Health Budgets</td>
<td>2009</td>
<td>39</td>
</tr>
</tbody>
</table>

*The number of sentences within which ‘personali*' occurred, excluding irrelevant hits (e.g. personality)

Table 2: Frequency of usage of personalise/personalisation in speeches of New Labour Prime Ministers and Secretaries of State for Health

<table>
<thead>
<tr>
<th>Speeches</th>
<th>Personalise/personalisation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(period of time in office in brackets)</td>
<td></td>
</tr>
<tr>
<td>Prime Ministers</td>
<td></td>
</tr>
<tr>
<td>Tony Blair (May 1997 - June 2007)</td>
<td>11</td>
</tr>
<tr>
<td>Gordon Brown (June 2007 -</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretaries of State for Health</td>
<td></td>
</tr>
<tr>
<td>John Reid (June 2003 - May 2005)</td>
<td>12</td>
</tr>
<tr>
<td>Patricia Hewitt (May 2005 - June 2007)</td>
<td>8</td>
</tr>
<tr>
<td>Alan Johnson (June 2007-</td>
<td>14</td>
</tr>
</tbody>
</table>

*The number of sentences within which ‘personali*' occurred, excluding irrelevant hits (e.g. personality)
It has become commonplace to explore New Labour’s public service reforms through contrasting the elements within them that embody Hirschman’s notions of exit and voice (or choice and voice) (See for example PASC, 2005, Simmons, 2009). However content analysis of those paragraphs which include the terms ‘personalise’ or ‘personalisation’ reveal a different dividing line, compatible with a fuller reading of Hirschman (1970). The analysis shows that personalisation is premised on organisational decline and disruption (requiring exit and voice) but also affirms the importance of loyalty, premised on continuity and consolidation. Thus there are strands in the policy text which position personalisation as a radical departure from existing service models, deliberately designed to be a disruptive response to failure, and others which emphasise personalisation in terms of a better understanding of and support for existing patterns of trust and interaction. These two elements are discussed in turn.

*Personalisation as disruption*

It is evident from the texts that personalisation is in large part a narrative of disruption in response to organisational failure. Many of the texts depict personalisation as a ‘radical’ agenda which will shake up the health service. As the white paper *Our Health, Our Care, Our Say* puts it, ‘There will be a radical and sustained shift in the way in which services are delivered – ensuring that they are more personalised and that they fit into people’s busy lives’ (DoH, 2006: 6-7). Rather than counterpoising choice and voice, there is a call for them to work together as drivers of change:

> Expanding choice and developing a personalised service for patients depends on giving patients a stronger voice. Where patients choose to go will be important, as it will affect where resources go and which providers thrive. But there will also be a greater readiness, nationally and locally, to seek and listen to the views of patients, and to act on them.

DoH, 2004a: 30
Disruption is presented in the texts in two different ways: exogenous and endogenous. At times personalisation is positioned as a response to broader social change, which renders existing organisational models inadequate. In other places the texts show support for personalisation as a tool to encourage further destabilisation in order to discipline providers and improve provision.

The notion of change as externally imposed on New Labour is evident in its embrace of the ‘new times’ thesis (Hall and Jacques, 1989; Allender, 2001). Acceptance of Giddens’ account of ‘reflexive modernity’ – albeit a selective one (Bevir, 2005: 42) – has led New Labour policy makers to reject existing state institutions as ‘monolithic’, insisting on the need for flexible organisational structures that better meet people’s expectations (Blair, 2004a, 2005). Personalisation is a key part of this agenda. Health Secretary Patricia Hewitt talks of ‘21st century aspirations - to be treated as an individual, to get personalised services’ (Hewitt, 2006). Her predecessor John Reid identified the need ‘to secure the NHS as a part of the personalised world of today’ (Reid, 2004). Brown talks explicitly of ‘new times’ (Brown, 2007b). As the Personal Health Budgets document puts it, there has been a ‘culture shift’ (2009a: 40). Elsewhere it states, ‘personal health budgets, and personalisation more generally, should be seen in the context of the wider movement to empower people to have more say and more control in all aspects of public life’ (2009a: 11).

Linked to this account of social change is New Labour’s embrace of new epistemologies, themselves also disruptive. Running through New Labour’s narrative of personalisation is an emerging view of knowledge, which is expressed in the Choosing Health white paper as, ‘a shift in public health approaches from “advice from on high to support from next-door”’. The Personal Health Budgets document includes the following exchange: ‘As one carer said to a professional: “You may be the expert professional but I am the expert carer”’ (2009: 23). This approach embodies a valuing of new sources of knowledge, in which patient or carer perspectives are recognized as a vital resource, particularly in relation to ‘micro’ level choices about care. According to the final report by health minister Lord Darzi, ‘[Users] expect not just services that are there when they
need them, and treat them how they want them to, but that they can influence and shape for themselves’ (2008: 26). In this account, personalisation becomes connected to the broader emergence of transformative knowledge communities associated with the open source movement (Henwood, 2008). The final Darzi report suggests that people want services that ‘instinctively’ respond to them, in the same sorts of ways that Amazon provides recommendations for books based on previous purchases (2008: 26). Gordon Brown has suggested that public services should offer the same opportunities for peer feedback as sites such as eBay and Trip Advisor (Cabinet Office, 2009).

As well as valuing user knowledge more explicitly, personalisation puts great emphasis on user control. The language of ‘control’ has been an important theme of service reform for Gordon Brown and seems to have displaced choice as the central dynamic of change (Brown, 2007b; Rossiter and Byrne, 2007: 65). Within the health texts this notion of control is unstable, shifting between personalisation as exhortation, empowerment and enforcement. The exhortation approach is evident in Personal Health Budgets: ‘People should be encouraged to take as much control over their health as they are able’ (DoH, 2009: 32). John Reid as health secretary develops the empowerment theme, stating that reforms are about ‘empowering [patients] to personalise their care to ensure the quality and convenience that they want’ (Reid, 2004). However, Ferguson positions personalisation squarely within New Labour’s broader neo-liberal agenda of enforced control: ‘the notion that the state should play a reduced role in the provision of services and that individuals should take on greater responsibility for their own lives (Ferguson, 2007: 394). Certainly the responsibility agenda is given a high profile within New Labour’s health reforms. Blair, for example, calls for a shift to an NHS that is ‘about personal responsibility as much as collective responsibility’ (Blair, 2006). The Choosing Health white paper, focused on preventative care, emphasises the importance of encouraging ‘self-management, personal responsibility’ (DoH, 2004b: 166).

Whilst the texts position personalisation as a response to exogenous disruptions – ‘new times’ – there is a clear agenda to encourage further destabilisation. Volatility is to be enhanced at the ‘meso’ level, through the encouragement of a diverse range of
providers, encouraging exit by patients and commissioning bodies. Darzi’s interim report makes clear that the independent sector will play a key role in ensuring responsive, personalised services. The report states, ‘we will encourage practice-based commissioners to use NHS funds much more flexibly to secure alternatives to traditional NHS provision where this would provide a better response to an individual’s needs’ (2007: 33). According to the Personal Health Budgets report, such budgets, ‘could support innovative services, potentially including those currently outside the scope of traditional NHS commissioning practice’ (2009a: 45). ‘Personalised purchasing’ is seen as a way to create a dynamic provider market, allowing ‘popular and successful services to grow, and others to adapt, shaping the available services to meet individuals’ needs’ (DoH, 2009: 9).

This notion of personalisation as deliberate destabilisation can also be seen in the ways in which the reforms are expected to drive changes at the ‘macro’ level of NHS funding. Although personal budgets are to be ‘cost neutral’, they will constitute a radical disjuncture from the tradition of risk-pooling in the NHS and a rationing system that was largely invisible to the patient (DoH, 2009a: 44). Indeed, the development of health budgets, to accompany those being used in social care, was rejected in a 2006 white paper for just that reason:

We do not propose to [extend individual budgets into the NHS], since we believe this would compromise the founding principle of the NHS that care should be free at the point of need. Social care operates on a different basis and has always included means testing and the principles of self and co-payment for services.

DoH, 2006: 85

However the Darzi reviews of the Health Service, published in 2007 and 2008, revived the idea of individual budgets within the NHS. The Personal Health Budgets document is explicit that, as a result of the reforms, ‘opportunities for risk pooling are reduced’ (DoH, 2009a: 33).
This end to risk pooling may constitute one of the most radical disruptions of personalisation in the NHS. Reflecting on the pilot scheme for personal healthcare budgets, Beresford asks, ‘How can such cash payments be squared with the philosophy of an NHS whose services are meant to be universally free?’ (2008: 17). It has certainly provoked concern, for example from trades unions about what happens when people run out of budget, or spend it on the wrong things (Unison, 2009). The *Personal Health Budgets* document states only that ‘the PCT [Primary Care Trust] still has to ensure that NHS care is available if the budget runs out or needs change’ (DoH, 2009a: 35). Although Brown affirms the necessity of comprehensive insurance and risk-pooling in the NHS (2008c), it is clear that personal budgets – along with new opportunities to ‘top up’ health spending from their own funds (Richards, 2008) – constitute a challenge to traditional principles of collective insurance.

A related aspect of personalisation is its potentially disruptive impact on equity and accountability as patients take more control over budgets. Within social care there have been debates about what is appropriate use of public funds (Beresford, 2007). Ellis notes staff hostility to the use of social care direct payments on ‘extras’ such as health club membership when services are so tightly rationed (2007: 211). The *Personal Health Budgets* document makes clear that there is a need to strike a balance between, ‘giving people control, keeping them safe, and protecting NHS resources’ (2009a: 22). However, the interpretation of what monies can be spent on is broad: ‘Broadly speaking, personal health budgets can be used for any goods or services agreed as part of a care plan that are likely to meet the individual’s agreed healthcare outcomes and would be appropriate for the state to fund’ (DoH, 2009a: 31). Darzi (2009) highlights the need for careful piloting and robust evaluation of the pilots to ensure, ‘the comprehensive NHS we all value so highly is not undermined’. However oversight may be difficult, particularly where people with long term conditions are eligible for health and social care budgets, which come with different eligibility criteria and are monitored by different legal frameworks (DoH, 2009a: 43).
As well as reshaping NHS funding at the ‘macro’ level, personal budgets will have an impact on ‘micro’ level discussions between doctors and patients, as rationing and budgetary concerns are made much more explicit. The *Personal Health Budgets* text recognises the shifting terms of the doctor-patient discussions, and the difficulties that this may present for some doctors:

> We recognise that practitioners in direct contact with the person receiving care and support may well find it uncomfortable to discuss the cost implications of different choices…[T]raining will be needed to help professionals to develop protocols for sensitive discussions with people whose care and support they are helping to plan’

*DoH, 2009a: 28*

This point relates to broader concerns about changing professional roles within a personalisation agenda. The emphasis on the user as expert has added to a sense that personalisation is designed to have a deliberately disruptive impact on professionals (Ferguson, 2007: 400; Beresford, 2008: 12). The rationale for personalisation draws on an ongoing New Labour theme that services historically were too focused around producer interests (Needham, 2007). As the NHS Plan puts it, ‘We live in a consumer age. Services have to be tailormade not mass-produced, geared to the needs of users not the convenience of producers’ (DoH, 2000: 26). According to Darzi’s interim report, reforms will ‘respond to the aspirations of patients and the public for a more personalised service by challenging and empowering NHS staff and others locally’ (Darzi, 2007: 5). New skills will be required and there is to be an enhanced role for advocates and brokers, as well as new types of staff such as community matrons and personal health trainers (DoH, 2004a,b). The NHS Improvement Plan explicitly links personalised services to the need for more flexible working by staff, which will be rewarded by better pay, in some cases linked to performance (DoH, 2004a: 58).

The exogenous and endogenous accounts of change are interwoven in the texts. At times it is unclear whether personalisation is responding to or driving disruption. Thus the *Personal Health Budgets* document asks, ‘Is there a cultural shift towards
personalisation?’ whilst later suggesting that personal budgets themselves will bring about a culture shift (DoH, 2009a: 12, 40). Within these accounts of disruption, loyalty may be best understood as a device which professionals have used to detract attention from substandard service, suppressing exit and voice (Le Grand, 2007). As Hirschman puts it, ‘…loyalty-promoting institutions and devices are not only uninterested in stimulating voice at the expense of exit: indeed they are often meant to repress voice alongside exit’ (1970: 92 – emphasis in the original). Here then, techniques to corrode loyalty can be seen as part of a government strategy to tackle a tendency of staff ‘to entrench themselves and to enhance their freedom to act as they wish, unmolested as far as possible by either desertions or complaints of members’ (Hirschman, 1970: 93).

**Personalisation as continuity**

Alongside the accounts of exogenous and endogenous disruption, there are strands within the personalisation narrative which can be best understood in terms of efforts to bolster loyalty, solidarity and continuity within the NHS. New Labour’s avowed aim is to use personalisation to deepen solidarity and equity within the NHS rather than destabilise it. This is an approach that has emerged over time, perhaps as New Labour began to see personalisation as a potential narrative. In its early white papers, there is a talk of balancing the ‘personal’ with the needs for national fairness and consistency (DoH, 1997, 1999). What emerges in Labour’s second term is a rather different account, in which ‘personalisation’ is a means to achieve fairness (Reid, 2003). The potential tensions are elided, a common New Labour trope, so that the contractions between them are ignored (Clarke et al, 2007). Blair calls for ‘services personal to each and fair for all’ (Blair, 2004b). Brown’s vision is for ‘a National Health Service that is also a personal health service’ (Brown, 2007b). According to Darzi’s final report, ‘Providing personalised care should also help us to reduce health inequalities, as the households with the lowest incomes are most likely to contain a member with a long-term condition’ (Darzi, 2008: 28). In the Foreword to the *Personal Health Budgets* document, Darzi affirms that personal health budgets are also part of a commitment to equity:
‘…personal health budgets should support local work to tackle health inequalities’ (DoH, 2009a: 5).

Although personalisation is explicitly focused on tailoring services to the individual, there are efforts to deny that personalisation is individualistic. The view of health outcomes expressed in the personalisation approach is one that emphasizes continuity of relationships, and their importance to better health outcomes: ‘NHS primary and community care services are strongly rooted in their local communities and patients, carers and their families rightly value the personal relationships and continuity of care that they provide’ (Darzi, 2008: 37). Gordon Brown makes clear that health is to seen in terms of a partnership between patients and professionals:

So if in the last generation progress in health care was seen simply in terms of the doctor administering antibiotics, in the coming generation it will be patients, doctors and NHS staff working together to improve health and manage conditions… the doctor not just physician but adviser; the nurse not just carer but trainer; patients more than consumers - partners.

Brown, 2008c

This disavowal of consumerism marks a contrast with the language of Blair and his ministers (Needham, 2007). It is part of a shift to seeing public services as ‘co-produced’ by staff and users, rather than the product of an adversarial struggle between consumers and producers (Needham, 2008b). The Personal Health Budgets document explicitly calls for a co-productive approach:

Personalisation of healthcare embodies co production. It means individuals working in partnership with their family, carers and professionals to plan, develop and procure the services and support that are appropriate for them.

DoH, 2009a: 23

Partnerships with other service users are also encouraged. The Personal Health Budgets paper notes that it may be possible for individuals to pool their healthcare payments as some recipients of social care direct payments have done (PHB, 2009, 35). However there is no discussion of the barriers to so doing. In social care, for example, Beresford
questions how personalisation can encompass collective provision of care (such as day centres and respite care), given the coordination problems of decentred budgets (Beresford, 2008: 12).

Thus there is a deep ambiguity within personalisation, based on New Labour’s attempt to position it as an agenda of radical and rapid institutional change – based on new epistemologies and competitive strategies – as well as an agenda of continuity and relationships, in which health outcomes are achieved through recognizing and supporting partnerships. This dual imperative – to foster stability, trust and partnership, whilst creating dynamic markets for personalised purchasing which incentivise staff and ‘responsible’ patients – runs through the texts. The calls for disruption and the appeals to solidarity are expressive of a central fault-line within the personalisation narrative.

Conclusion

Personalisation is an important theme in New Labour account of public service renewal, a softer-edged policy to that of choice, in which voice and solidarity are also valued. Quantitative analysis of speeches and policy document revealed that personalisation is an increasingly central narrative in the health texts, emerging in documents and speeches from the middle of New Labour’s second term (around 2003). It is a theme developed explicitly by Blair and his health ministers. Brown has avoided talking explicitly about personalisation in health, although he has pushed the agenda of personal budgets further than Blair as part of a commitment to a health policy that is ‘personal to you’.

Personalisation is a highly salient narrative in relation to Hirschman’s framework, since it is premised on an assumption of organisational decline and discontinuity but also reaffirms the importance of trust, loyalty and solidarity. Whereas it has been common to analyse New Labour’s public service reforms by comparing choice-based reforms with those based on democratic processes of voice, the important dividing line in relation to
personalisation seems to be between exit/voice as accounts of failure and disruption, and loyalty as an account of consolidation and solidarity. The New Labour narrative of personalisation reaffirms the importance of ‘folk’ knowledge and relationships of care, but also seeks to use markets and user voice to discipline and destabilise providers. Whereas for Hirschman exit, voice and loyalty pulled in different directions, New Labour is keen to affirm the importance of all three imperatives.

Some of the ambiguities of the relationship between exit, voice and loyalty are related to the nature of health as a public good. Hirschman is clear that loyalty will operate differently in relation to public rather than private goods: users will be more tempted to use voice since exit from these goods can only ever be partial (1970: 98-100). New Labour’s account of personalisation may be best understood as an attempt to permit certain kinds of exit and voice, and encourage certain kinds of loyalties. Service users are expected to be just loyal enough – willing to take more responsibility for commissioning and managing their care, and supportive of the NHS as a public good, but actively pursuing the best package of provision for their particular needs. Staff are also ambiguously located – key partners in relationships of care, but also barriers to reform, needing the prod of exit and voice.

There are forms of exit, voice and forms of loyalty at the macro, meso and micro levels. Funding is being reallocated, but within the context of a commitment to collective insurance. Users are encouraged to shop around between providers, but to use those providers sanctioned by the NHS. At the frontlines, partnerships are to be redefined but newly valued. As in social care it is unclear how these reforms will reshape patterns of provision. Are personalisation reforms best seen as efforts to make the users of public services more closely resemble private sector customers, choosing packages of services from increasingly deskillved professionals, as part of a ‘cash for care’ agenda (Ferguson, 2007: 400; Fitzgerald, 2008; Beresford, 2008: 12)? Or are they expressive of a commitment to more co-productive approaches, which foster new forms of self-organisation and peer collaboration, recognizing that ‘people need to be rooted in mutual support networks, and that not everything can be bought’ (NEF, 2008: 15)? The
implications of personalisation are not yet known, particularly in an economic context where the amount of money available for public services is predicted to contract severely. With personal health budgets for those with long-term budgets not yet piloted, it will be several years before budgets become part of mainstream health provision.

Surveying 10 years of New Labour reforms of the NHS, Paton finds ‘the politics of the rubbish bin’…rather than…a “rational” approach’ (2008: 26). It seems likely that personalisation too will prove patchy and incoherent, reflecting its ambiguous positioning as an agenda of disruption and continuity. New Labour’s tendency to draw on ‘heterogenous’ strands of reform, whilst ignoring the tensions between them, has been widely noted (Hall, 2003; Smith, 2004: 220). To locate the personalisation narrative at the crux of a tension between disruption and continuity is consistent with broader accounts of New Labour and indeed of new public management reforms more generally (Shaw, 2007; Pollitt, 2008). Personalisation has been billed as radical and new, part of a new welfare settlement which can overcome the shortcomings of ‘paternalism’ and ‘consumerism’ (Miliband, 2004). It appears though that it is aimed not at resolving earlier tensions but simply relocating them. Under personalisation the frontline becomes the site not only for service provision, but also for commissioning services, employing staff and allocating resources. It is here that staff and service users must make sense of an initiative that positions them as partners and as adversaries.

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