Consumer voice? The response of patients’ organisations to the introduction of choice policy in the English National Health Service

Micky Willmott

Health Services Research Unit, Department of Public Health Policy

London School of Hygiene and Tropical Medicine

michaela.willmott@lshtm.ac.uk

Paper prepared for workshop 15 ‘Voice and Choice in Health Politics’

ECPR Joint Sessions of Workshops, Lisbon, 14-19 April 2009.
Abstract

This paper addresses the question of forms and shapes of voice and choice in healthcare systems. It presents findings from a recent empirical study examining patients’ organizations’ perceptions of choice and choice policy in the English National Health Service and explores the role of patients’ organisations in representing the voice of citizens-patients in development of the national choice policy. It discusses the extent to which citizens-patients have had a decisive or advisory role in policy-making on patient choice, including their influence on the choices offered to citizens-patients.

The paper argues that patients’ organisations are ambivalent towards choice because the aims of the policy are disparate and they do not believe that it is a priority for the citizens-patients whom they represent. However, they are reticent to exit the policy arena because of their belief in their responsibility to provide voice for citizens-patients in national policymaking.
**Introduction**

In the United Kingdom, options of exit (e.g. choice of General Practitioner) and voice (e.g. complaints) have been available to patients since the inception of the National Health Service (NHS)(Greener 2008). This paper applies Hirschman’s concept of exit, voice and loyalty to data from a recent empirical study of patients’ organizations (POs) that examined their perceptions of recent efforts to extend choice and choice policy in the English NHS and their experience of the choice policy process. Hirschman’s concept can also be used to analyse the UK policy on patient choice (DH 2003a) but this is not the central focus of this paper. Rather, it aims to explore how POs, as one way of institutionalizing voice (Hirschman 1970, p.41) perceive exit (choice of provider) and voice in English national health policy. By using choice policy as a case study, it considers PO opinions about exit at micro (individual) and meso (national, systemic) levels.

First, the paper introduces POs as a form of voice in the NHS and provides a brief background to choice policy in the English NHS. Second, the study design and methodology are described, along with the themes emerging from these data. Third, Hirschman’s concept of exit, voice and loyalty is used to interpret the data and discuss POs’ perspectives on patient choice and voice in national policy. It goes on to explore the contribution of exit, voice and loyalty to understanding groups such as POs in the health policy process. It argues that exit, voice and loyalty does not fully explain POs’ approach to the choice policy process but despite its focus on individual voice, it can be applied to POs to show how their voice is “political action par excellence” (Hirschman 1970, p.16). The paper concludes by summarizing the findings and usefulness of Hirschman’s model in understanding POs in the NHS.

**Background**

*Patient Organisations in the UK health system*

The option to exit is limited in health services, particularly in a universal system such as the NHS, and people do not have equal opportunities to exit. Therefore, lay participation

---

1 The research was conducted as part of my Masters degree course (2007/08) and contributes to my ongoing PhD research.
Consumer voice? Patients’ organisations and choice policy in the English NHS.

(‘voice’) in health is commonly viewed as a ‘good thing’ (Salter 2003) that contributes to the responsiveness and accountability of the health service, a belief that is often associated with democratic and consumerist ideals (Lupton et al. 1998).

The NHS has always been a service run via local executive boards under the central direction of the Department of Health (DH). Since its inception, the DH has encouraged local NHS organisations to set up mechanisms to consider the interests of service users (Ham 1977), thereby institutionalizing voice. Formal, local arrangements for patient and public involvement in the NHS were established with Community Health Councils (CHCs) in the 1970s and have been through several iterations, with current arrangements including patient advocacy services (PALS) and Local Involvement Networks (LINks) (Hogg 2007). Arrangements for participation at a national level have also taken several forms, with recent developments including the NHS Centre for Involvement (NHSCI 2009). These mechanisms use various “locus of voice” (Hirschman 1970, p.41) combining individual, lay participation with representative, collective participation. However, there is little empirical evidence of the impact of patient and public involvement on health services and policy (Fudge et al. 2008; Nilsen et al. 2006). Nevertheless, this range of approaches reinforces Hirschman’s prediction that the institutionalization of voice would occur at multiple levels (Hirschman 1970, p.42).

Alongside efforts to develop patient and public involvement, the DH has fostered the longstanding PO engagement with the UK health system (HMSO 1998) and encourages their participation in policy processes, such as consultation and working groups (Baggott et al. 2005). Indeed, the DH supports National Voices (formerly the Long Term Conditions Alliance), an umbrella organisation established by and working for POs representing users of health and social care in national policymaking which was in development during this study (National Voices 2008).

POs’ involvement in health services as providers predates the development of the welfare state (Gorsky and Mohan 2001), and their advocacy role in the NHS is also well established (Ham 1977). Current debates about POs in the NHS are at least partially linked to the development of the ideology of a ‘third way’ (Giddens 1998) and changes in NHS management (Titter et al. 2003). However, their role in “promoting voice has not been given the same emphasis as [their] role in promoting choice” through providing
services (Pratten 2007, p.80). POs articulate collective voice as well as facilitating the direct involvement of individual patients.

This paper is particularly concerned with their role as a collective voice, which “implies [that] some delegation and representation” is required (Contandriopoulos 2004, p.327). Representation is a fundamental challenge associated with voice and there are many approaches to this and may go beyond notions of democratic representation (Lupton et al. 1998). Although Hirschman notes that consumer voice is “essentially an art constantly evolving” (1970, p.42), the concept of exit, voice and loyalty does not explore issues of representation that are implicit in institutionalized voice.

POs’ representative role in “interest articulation” (Hirschman 1970, p.30) is generally accepted as legitimate (Taylor and Warburton 2003) although it is not unproblematic because of their “particularism”, power imbalances between organizations (Taylor and Warburton 2003), state and corporate colonization (O'Donovan 2007) and questions about their internal democracy (Baggott et al. 2005). Moreover, there is a lack of clarity about who selects POs as representatives (Beresford and Campbell 1994) and they may respond selectively to opportunities to participate in policy making due to factors such as resource constraints (Harris et al. 2001). Nevertheless, due to practical difficulties, “it is unlikely that it will ever be possible to avoid the use of proxies for the voice of users and the public” (Titter and McCallum 2006) and the DH has acknowledged that there is an ongoing role for POs in supporting the work of the NHS (DH 2008b).

Definitions of POs are contested and context-specific (Baggott and Forster 2008). This paper focuses on POs as a mechanism for “promoting and/or representing the interests of users and/or carers” at a national level in the English health system (Baggott et al. 2004), a form of ‘proxy’ in the policy process (Lupton et al. 1998; Titter et al. 2003). Drawing on a typology developed in the UK (Baggott et al. 2005), POs in this study are defined as formal, institutionalised non-profit organizations (Clemens 2006; Vincent and Harrow 2005) representing people with a specific condition or disease (e.g. HIV/AIDS), a particular population (e.g. older people) or both (e.g. children with cancer). Although not

---

2 Hirschman (1970, p.121) argues that “voluntary associations” are likely to react strongly to voice and exit of members however it is beyond the scope of this paper to discuss the application of exit, voice and loyalty to POs as firms.
formally elected, POs provide descriptive or symbolic representation as they are constituted of people with experience or provide accounts of typical experiences (Contandriopoulos 2004). From Hirschman’s perspective, POs are a form of “non-market social institution” (1970, p.16-19) which conduct political action to provide signals of “collective choice” (Holzer 2006).

There are many frameworks for describing groups like POs in the policy process, many of which draw on social movement and interest group theory. However, these tend to describe the features of groups and assume an association between organisational characteristics and policy outcome (Baggott et al. 2005). Exit, voice and loyalty complements these models, viewing institutionalised voices, including those of consumers, as interest groups (Hirschman 1970, p.42) although as discussed later, he makes little reference to theories of collective action.

Grant’s typology of insider/outsider groups is commonly used to describe the nature of groups’ access to the policy making (Grant 2000). However, it equates access to decision makers with influence, ignores the gatekeepers who guard access and conflates group strategy and status (Baggott et al. 2005; Maloney et al. 1994; Whiteley and Winyard 1987). Hirschman describes a similar notion of “voice from within and voice from without” in situations where organisations provide public goods, such as the NHS. However, he appears to distinguish this status from strategy, which might be to “fight or flight” (Hirschman 1970, p.104-108).

A group’s strategy may be of secondary importance to their status, which is ascribed by policymakers on the basis of whether or not they perceive that the group provides a valuable resource (Maloney et al. 1994). Baggott et al (2005) found that group characteristics such as credibility and the quality of their input affected their status. Based on empirical study of nonprofit organisations in the HIV/AIDS field in New York, Lune and Oberstein (2001) suggest that group status is ascribed to them but is also contingent on their relationship with, and the positions of, other groups in that organisational field. For example, if one organisation chose to specialize in a sub-field or issue, others were likely to avoid it.
Group strategy may be the result of the relationship between many variables (Whiteley and Winyard 1987) including the environment (e.g. political environment) and group characteristics (profit or not-for-profit status, financial support, history, skills, resources and membership) (Maloney et al. 1994).

As well as status and strategy, other features may affect POs’ impact on policy, including whether the issue is a government priority (Baggott et al. 2004), the stage of the policy cycle, the nature of the policy and the networks of actors involved (Casey 2004). Critically, POs, like individual patients, lack power to impose sanctions if their demands are not met and this limits their influence on policymakers (Ham 1977). Due to their function representing a range of vulnerable people and their lack of internal processes for balloting members, POs generally operate within the bounds of loyal behaviour and cannot threaten to exit the policy process, which weakens their “bargaining power” (Hirschman 1970, p.82). It is therefore important to consider the value which collective, ‘institutionalised’ voice (such as POs) brings to the policy process, especially in relation to individual consumer voice, and how they deal with their apparently weak bargaining position.

Choice policy in the English NHS

In 2003, building on a pledge in the NHS Plan (DH 2000), the DH introduced a policy to increase patient choice in the NHS in England (DH 2003a). The key element of the policy was the introduction of a national system allowing patients to select their care provider, the date and time of appointments. Initially, the policy related to first hospital outpatient appointments but has spread to choice in other areas of care. The policy was facilitated by various structural changes, including the introduction of a ‘market’ within the NHS where care can be delivered by various public, private and third sector providers.

A formal, public consultation was held about the policy that invited written comments as well as direct participation in working groups and events, and there is evidence that many POs engaged with this process (DH 2003b, c). In response to the potential information asymmetry between patients and providers (Propper et al. 2006), the DH also developed a programme to provide patient information which mentions POs as potential information providers (DH 2004a, 2007a).
In addition to the core policy, guidance on choice for people with long-term conditions, written in conjunction with POs, was published in 2007 (DH 2007b). Unlike the other choice policies, this document has received little critical attention, perhaps because it shifts the focus towards the relationship between professionals and patients and the importance of patient participation in care planning and local service development.

The DH presents patient choice as a mechanism for achieving fairer allocation of health care resources, improving patient experience (by promoting individual involvement in care), increasing efficiency and system responsiveness (DH 2003b) and more recently, individual responsibility to choose healthy lifestyles (DH 2004b). There has always been opportunity for patients to make (limited) choices in the NHS, for example patients can choose their general practitioner (Greener 2008). Patients can also exit the NHS to receive care but this option is generally limited to those who can afford private insurance.

Choice has been portrayed as a response to the increase in consumerist values in wider society but it has been argued that this is a rhetorical, political device to gain legitimacy for reform (Greener et al. 2006). Indeed, the multiple, potentially contradictory objectives for patient choice have been criticized (Thomson and Dixon 2006) and it is suggested that it overestimates the power of consumers (Fotaki 2005). As yet, there is no evidence that choice aids equity in access or improves outcomes and it might increase inequalities (Forster and Gabe 2008; Propper et al. 2006; Taylor-Gooby 2008).

**Study methodology**

Choice policy was selected as a case study because it enables investigation of issues of consumerism and democracy in the NHS and because it is known that POs have been involved in the policy process. Data were obtained from two complementary sources; documents from national POs and semi-structured interviews with national PO staff.

Qualitative data emphasize participant perspective and enable exploration of process (Murphy et al. 1998). Documents provide an efficient way of obtaining information about a policy, ideas underpinning it (Abbott et al. 2004) and evidence of PO tactics but they provide little information about the processes that lead to their production (Green and Thorogood 2004). Interviews provide an opportunity to find out about the formation
of ideas as well as exploring individual experiences. They also enable people to clarify positions and ideas that may have changed since they were recorded in documents, which is particularly important in dynamic policy environments. By using these two sources, it was not the intention to obtain a ‘truth’ but rather to overcome the “context-boundedness” of sources (Silverman 2005, p.121) although both as artifacts of the time and context in which they were produced. Taken together, these data provide a detailed picture of POs’ perspectives on choice and choice policy.

Purposive sampling was used to identify POs (covering at least England) with local branches or groups. POs with local branches were chosen because this research aimed to inform the development of my PhD research into POs and local health policy and decision-making. This “deliberate, non-random” sample (Bowling 2001, p.380) aimed to identify information-rich sources who had considered choice and experienced the choice policy process. Organisations were included in the sample if they had responded to the national consultation (DH 2003b), were mentioned in choice policy documents or represent patients covered by the policy (e.g. people with long-term conditions).

This sample method only identified ‘insider’ groups (Grant 2000) and could have introduced homogeneity in terms of organisational characteristics (e.g. size, resources) which might have impacted on the data generated. However, there was scope for heterogeneity in other characteristics, particularly regarding the constituency represented (e.g. population group, condition-based group). A small sample was targeted because of time constraints for conducting the research and because it the study aimed to assess the feasibility of the case study approach for a larger study.

Fourteen POs fitted the criteria and were included in the sample. Named contacts were identified from each organisation’s website and by phoning the organisation. These were the head of policy or campaigns where they exist (one was the chief executive). Recruitment was by a letter sent to the contact, inviting them to participate followed by reminder emails and telephone call. People who agreed to participate were sent a confirmation email, summary information and a consent form before the interview.

Documents were requested from everyone contacted for interview and through searches of the organisations’ websites. Any type of document produced from 2003 onwards that
described ideas or action on DH patient choice policy was included (e.g. newsletters) as well as consultation responses. Other documents using the term ‘choice’ were found but these were not included in this study.

Interviews were conducted by the researcher in July and August 2008 and were recorded and transcribed verbatim. Field notes were also taken immediately after each interview to reflect on emerging issues about choice and the policy process, as well as impressions about the context, flow and rapport in the interviews. The interviews were structured according to a topic guide. The guide was not piloted due to lack of time but it was checked with researchers at LSHTM who have expertise in interviewing and who are working on a larger research project on choice in the NHS. It was amended to cover issues specific to each organisation and after the first two interviews to ensure that issues of equity were covered as this was important in the first two interviews. The same topics were included in a data extraction sheet to capture documentary data, as well as descriptive information including document type, publisher, date and source.

Transcripts and documents were assigned a random number for identification. Whilst the time lag since the introduction of choice policy may have led to recall bias, it also meant that interviewees could reflect on their perception of the whole policy process. Interviews were carried out at the time when the publication of a review of the NHS was anticipated (DH 2008a) which may have affected interviewee responses.

Data were analysed using thematic content analysis. First, two documents were annotated line by line using open coding. Codes were grouped into initial conceptual categories. All documents were re-read in-depth and coded using the preliminary codes, with categories being amended in an iterative process until all data were included. Categories were checked and grouped into themes. The same process was repeated for the interview transcripts. Finally, codes and categories developed in the documentary analysis were compared with those from transcripts. These parallel codes and categories were tested against each other and with reference to the original data to develop a set of themes that encompassed all data from both sources.

To maximise validity, if a document or interviewee presented different views to dominant themes it was noted. Emergent themes and quotes were sent to interviewees for member
validation and feedback was incorporated into the analysis (Seale 1999, p.64). One interviewee requested a minor change to one direct quote to reduce the ambiguity of a phrase they used.

The LSHTM ethics committee approved the research. In adherence with their guidance, permission was sought from interviewees to use direct quotes in this report because of the small sample size and potential for identification and reputational risk. All interviewees signed a consent form and gave permission for their interview to be quoted. All quoted documents are in the public domain.

Results

Data were obtained from 11 POs. Seven people from six national POs were interviewed, eight POs declined to be interviewed. Two POs declined to be interviewed but sent documents instead. A total of 14 documents were used, eight of these were downloaded from PO websites. Table one shows information about the POs and data they provided.

Table 1: Types of patient organisations and data included

<table>
<thead>
<tr>
<th>Type of PO</th>
<th>Number of interviews (identifier)</th>
<th>Number of documents (identifier)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease-specific</td>
<td>2 (i2, i3)</td>
<td>8 (d3, d4, d6, d7, d8, d9, d10, d14)</td>
</tr>
<tr>
<td>Population-based</td>
<td>3 (i1, i4, i5)</td>
<td>4 (d1, d2, d12, d13)</td>
</tr>
<tr>
<td>Both</td>
<td>1 (i6)</td>
<td>2 (d5, d11)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6 interviews</strong></td>
<td><strong>14 documents</strong></td>
</tr>
</tbody>
</table>

Three broad themes and thirteen sub-themes were identified (table 2). The next section summarises these, illustrated by interview and documentary data (‘i’ and ‘d’ respectively, the number is the anonymous identifier assigned to each piece of data).

Table 2: Themes emerging from documents and interviews

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| 1. Making sense of the ‘choice agenda’ | a. A means or an end?  
b. Who wants choice?  
c. Choice of what and how  
d. Making choice meaningful |
| 2. Choice and the components of care | a. Control and empowerment  
b. Needs, rights and entitlements  
c. Fair choice and equality  
d. Help to make decisions  
e. Creating a person-centred system |
Themes | Sub-themes
---|---
3. PO experience of the “higgledy piggledy policy world”³ | a. Using the right words and forming ideas  
b. Experience and evidence  
c. Engaging with policymakers  
d. Putting policy into practice

**Making sense of the choice agenda**

POs noted a lack of clarity about the policy purpose, that it can mean “different things to different people” (i6). Choice policy is perceived as the DH agenda and interviewees stated that choice is not something that their constituency calls for or prioritises. As one interviewee noted, it may be a “slightly artificial concern” (i5) and another explained:

“If you could actually deliver appropriate care, high quality care that didn’t involve choice, we wouldn’t be focused on it, to be honest. It’s a government priority and it’s a policy campaigning hook” (i2)

POs are clear that the quality of care and how it is delivered is the priority for the people that they represent, not when and where care is provided. They are familiar with the notion of choice as a mechanism or a “means to an end” (i2) to improve quality in the health service. Most POs acknowledge that “nobody could disagree with the principle of individual choice” (i5). However, some perceive choice as a luxury as patients often do not have “meaningful choice” (i3, 5) due to difficulties accessing services.

Whilst interviewees perceived that it would overstep their charitable status to take a stance on the ideological motivations for the choice policy, all POs highlight concern about the consequences of the policy agenda; that the people they represent might not have fair opportunities to make choices, as they do not have “access to the same choices as other people” (i4). POs acknowledge inequalities within their constituency, for example, black and minority ethnic groups or people from different socio-economic groups. However, they focus on the impact of geographical variation in service provision on choice and note the potential for choice to increase inequalities.

**Choice and the components of care**

POs strongly associate choice with patient control and empowerment, seeing it as a challenge to paternalist models of care and the opposite of being “told what to do” (d7).

³ Interview 3
POs use choice as an opportunity to promote patient involvement in care planning and advocate that patients and carers should be equal partners who agree care plans with health professionals.

POs are keen that people should be able to “take as much control as they wish” (d10) and have “freedom to make ‘mistakes’” (d3) but only two consider the impact of practical limits or rationing on individual choice. Only one PO noted that individuals might be held responsible for treatment choices (i2).

The process of individual decision-making is perceived as an opportunity for people to articulate needs and question why these are not met. POs note that health professionals should advise people but that it is; “the individual’s right to decide what is best for them” (d5) although two POs mention people’s right not to make choices if they prefer professionals to choose for them. This demonstrates a perception that the NHS should aim to meet patient expectations, framing this in terms of rights and entitlements.

POs accept that information is critical for decision-making although they are skeptical about the reliance on information alone. They promote their role as information providers and their own initiatives that they believe reinforce patient empowerment (e.g. self-management tools, training and advocacy services). They highlight concerns about how people navigate the complexities of the health service and forecast the impact of systemic factors (e.g. need for transport) on the success of patient choice.

*Patient Organisations’ experience of the “higgledy piggledy policy world”*

Data show the range of tactics POs use at different stages of the policy process. For example, two POs described consultation exercises with their members to establish their position on choice, demonstrating their uncertainty about the concept but also an awareness of the need to base their activity on constituents’ experience. One document reports on a party conference fringe meeting on choice hosted by POs. Along with setting examples of practice, this is a typical tactic, as one interviewee noted such lobbying is; “one of our mainstream ways of doing business” (i6).

POs use people’s experience as evidence to describe to policymakers “what the reality is”, perceiving that: “people’s stories… [are] the most powerful thing” (i1). They also use projects they have funded to substantiate arguments and as examples of good practice...
in service delivery, although not directly relating to choice policy. As one interviewee explained, projects are “a means for pushing our influence everywhere” (i2).

All interviewees reported a variety of formal and informal engagement with policy-makers about choice and other policies. They are sometimes involved in discussions with officials or working groups before a policy is published although only three reported being involved in this way about choice policy. POs seem to particularly value informal methods of engaging with policy-makers and perceive that it is important to build relationships with officials to seize influencing opportunities. One interviewee justified their involvement in choice policy, despite their reservations about it, saying that:

“policy evolves and if you’re not there, and you’re not evolving with it, you don’t know what you would end up with” (i2).

However, POs also noted the resources required to maintain these informal relationships and that this work is made difficult by the breadth of policy initiatives with which they could become involved.

Two POs mentioned in DH choice policy documents were unclear how they came to be included. POs noted that they had conversations with officials (at the request of the DH) about what choice “might mean in practice” (i1). One interviewee described how DH officials have contacted them regarding policy implementation but felt that they had little impact because the policy approach had already been agreed (i5). This reflects a general dissatisfaction amongst POs about the effectiveness of formal consultation processes. Nonetheless, POs seemed willing to respond to DH requests for specific input despite cynicism about the impact they might have.

POs said that they have been reacting to government ideas and proposals about choice. Reflecting their lack of ownership of the policy, one said they were “on the back foot with this policy” (i1) and another indicated that; “for the most part we’ve kind of sat back” (i3). Nevertheless, they opportunistically ‘package’ ideas and evidence for policymakers and two described how they relabelled their priorities as choice, others noted that they explicitly state how the changes that they advocate are relevant to the DH policy. Whilst one PO is conducting a campaign to “raise awareness” of the issues
around choice (d6), another said that they had avoided mentioning choice in their health campaign because the word was “getting used too much” (i1).

None of the interviewed organisations had evaluated their constituents’ experiences of choice, instead relying on published surveys and research (DH 2008c). One of the main ways that POs get feedback about policy implementation is when people telephone or email with problems, but no POs were aware of any communication about patient choice.

**Discussion**

Generally POs support patient choice, perhaps because it can have many meanings. However, there are differences in the extent to which POs have ruminated over the concept and organisational positions on the policy vary. POs see patient choice as a means, not an end in itself. Unsurprisingly, POs welcome the idea that the NHS should be more responsive to citizens-patients. However, they are unconvinced about whether exit (choice of provider) is an effective way to achieve this. This could show that they share Hirschman’s belief that “state enterprise… is likely to be far more sensitive, at least up to a point, to voice… than to exit” (Hirschman 1970, p.74).

POs’ concerns about choice policy reflect research observations. For example, they perceive that it overestimates the power of individuals (Fotaki 2005) and are concerned about the consequences of choice policy on more vulnerable groups. This could demonstrate how POs are loyal to their group (Hirschman 1970, p.112).

All POs in the study support choice as an essential component of individual care planning although they interpret exit (choice of provider) as a luxury compared to other issues (e.g. access). In this way, POs equate choice with voice in individual care planning and believe that patient empowerment may be a potential benefit of choice policy.

POs’ advocacy of patient rights and individual decision-making seems to reinforce the suggestion that they are a form of consumer movement (Allsop et al. 2004). However, one PO explicitly stated that they do not support a consumer model of healthcare (i6). Whilst POs share a belief in concepts such as access and information with consumerism, they are suspicious of such ideologies as a means to achieving better services (Lupton et al. 1998). POs are aware that choice (exit) reflects a particular ideology, linked to the marketisation of the NHS. Indeed, POs perceive that consumerist values have been used
as a lever for introducing choice (Greener et al. 2006) and this seems to add to their reticence about the policy.

Unlike Hirschman, who considers that exit and voice are both concerned with quality, POs were skeptical of the link between exit (choice of provider) and quality, although when they interpreted individual voice in care planning as an essential element of a quality service. All respondents noted the importance of quality of services over the opportunity to choose (exit). This is perhaps because POs tend to represent people for whom exit from the NHS is not possible because the nature of their conditions means that they might not get coverage from private providers, so there are few available substitutes outside of the NHS. Due to their reliance on the NHS and the lack of exit opportunity, individuals may not voice their dissatisfaction which may explain why POs persistently advocated quality and that exit should not be necessary even as a means to an end.

Evidently, the POs perceive lobbying as a worthwhile activity and POs participated in most stages of the choice policy process, except evaluation. However, the extent of their participation varies, with most evidence relating to efforts to influence choice policy formulation and reactive work to aid implementation. In common with existing research, data show that POs perceived the formal consultation as largely “cosmetic” (Maloney et al. 1994). POs are clear that they were not involved in issue recognition and they do not identify lack of choice of provider as a priority issue for their constituents. Moreover, they could not indicate whether they had affected the policy development. It seems that choice policy is an example of an initiative where POs invest in political action despite the likelihood that there will be “negative returns to voice” (Hirschman 1970, p.31).

The tactics POs reported are similar to those found in the literature, for example, formal and informal contact with DH officials, as well as some wider parliamentary lobbying at party conferences (Baggott et al. 2005). Data reinforce evidence from other studies (Jones et al. 2004) regarding the “opportunity costs” (Hirschman 1970, p.39) that POs face in participating in the policy process and this might explain the largely reactive tactics they adopted. Interviewees reported how the complexity and size of the health policy portfolio creates difficulties for them, particularly because there is a lack of coordination between policy teams in the DH. In addition, they cite the impact of structural changes in the NHS and ministerial changes on choice policy. Although this
demonstrates their understanding of the NHS, it is not clear whether these factors also affected their participation.

Two organisations invested in internal consultation to gauge their constituents’ views on choice (including choice of provider). This shows POs are aware that their “bargaining power” (Hirschman 1970, p.40) is largely based on their ability to represent their members’ experiences and reinforces findings from studies into the legitimacy and contributions of POs in policy processes (Baggott et al. 2005; Taylor and Warburton 2003). It also highlights how costly voice can be and the organisational capacity it requires. As Hirschman notes:

“for voice to function properly it is necessary that individuals possess reserves of political influence which they can bring into play when they are sufficiently aroused” (1970, p.70-1).

Interviewees also showed their sophisticated calculation of the costs and benefits of participation, noting that it has the added value of maintaining the profile of the people and/or conditions that they represent among the range of other voices in the policy process, including other POs. This corresponds with findings in other studies (Lune and Oberstein 2001), but highlights how the concept of exit, voice and loyalty omits to explore the relative impact of different consumer voices acting upon an organization that might have different demands and levels of bargaining power.

POs understand their relative power in the health system and that despite the fact that they do not perceive choice as a priority, it is important not to be seen as “anti-something” (i2) in order to maintain their legitimacy with policymakers. This demonstrates how POs are “aware of, and [recoil] from, the prospective consequences of their exit” (Hirschman 1970). By remaining loyal to the DH by engaging at least minimally with the choice policy process, POs may be attempting to avoid “hypothetical damage” incurred by the additional deterioration of the service (Hirschman 1970, p.103) and are demonstrating their awareness that the threat of exit would have little impact. There may also be self-interest at work too, as if POs jeopardised their status with the DH, they would not have a job. Moreover, as public goods, POs are required to remain
engaged with the policy process despite potential costs. As Hirschman states, if loyal behaviour;

“increases along with the cost of remaining a member, the motivation to exit need not become stronger as deterioration proceeds although undoubtedly our member will become increasingly unhappy” (1970, p.101-2).

All organisations had ‘insider’ status (Grant 2000) and power to define POs’ status remains with policymakers. For example, two organisations were consulted by policymakers regarding choice policy implementation but did not consider themselves to be insiders.

POs perceive that reframing their ideas to fit the government policy agenda is a pragmatic strategy, but it also demonstrates the power of the DH to influence group behaviour. POs feel they cannot be too critical of the policy agenda, affirming the view that voice in the health field is “oriented towards consensus and confirmation rather than debate and opposition” (White 2000) and demonstrates the importance of power in exercising voice (Lukes 1993). This counters Hirschman’s notion that voice includes expressions of “opinion and discontent” (1970, p.39) and “dissatisfaction” (1970, p.76) although interviewees provided examples of how they had verbally indicated their views on the policy, suggesting that voice might be different in public and private. Moreover, findings support other studies which have suggested that POs’ voice manifests in other ways for example, by providing expertise and representations of patients’ lived experience (Baggott et al. 2005). This suggests that Hirschman’s concept of voice does not provide an adequate description of where and when voice occurs and how it manifests, particularly when representing multiple consumers.

In the absence of conceptual clarity about POs and comprehensive frameworks with which to analyse their role in health politics, Hirschman’s concept of exit, voice and loyalty makes a useful contribution to understanding the emergence of POs. It suggests that as exit is difficult for individuals in the NHS, many forms of voice, such as POs, have emerged to represent individual voices. Whilst this can be perceived as political action, it also makes consumer voices manageable for administrators by collating their feedback. Due to their lack of bargaining power and the necessity to be loyal to the NHS
on behalf of the citizens-patients who they represent, POs and other forms of voice might therefore be seen as aiding administrative efficiency (Salter 2003; White 2000) as well as a form of political participation, as Hirschman suggests (1978, p.90). Findings from this study reinforce the assertion that “notwithstanding the greater possibilities for the exercise of ‘voice’ on the part of the voluntary sector”, the “policy agenda continues to be set by government” (Lewis 2005). The locus of power in the policy process is clearly a determining factor on voice and this is not adequately addressed by Hirschman’s concept.

No data were collected directly from policymakers regarding their perceptions of groups and so it is difficult to assess the sensitivity of the organisation (DH) to POs’ response to choice policy. Like other empirical studies, findings from this study cannot rigorously demonstrate the impact of POs on policymakers. Although Hirschman appears to view both exit and voice as means to an end (quality and responsive services), findings from this study suggest that POs perceive voice differently – as both a means to an end and valuable in of itself, whereas they are ambivalent about the effect of choice of provider.

It is not possible to confirm or deny the argument that voice may be more effective than choice (exit) in promoting responsive services (Greener et al. 2006) and there may be others factors, not just voice and exit which influence organisations. Indeed, the application of Hirschman’s concept of exit and voice to POs raises the question that if POs did not represent voice on behalf of citizens-patients in the policy process, whether individual voice (e.g. complaints) and individual patient choice would be sufficient to make the NHS responsive.

In applying the concept of voice to POs, it is necessary to assume that they function as an individual even though they represent many voices. However, since Hirschman developed the concept of exit, voice and loyalty, there has been a proliferation of modes of collective voice and increased conceptual frameworks with which to understand them, for example as social movements, interest groups, networks and voluntary organisations. These are founded in different views of the relationship between “the private and the public, the economy and the state” (Alford and Friedland 1975, p.430). Whilst Hirschman explicitly bases the concept of exit, voice and loyalty on potential connections between economic (consumerist) and political (democratic) perspectives, it is not easy to see how it adds to emerging models of understanding collective political participation,
particularly because of its focus on individual voice. As the number of POs grows (Baggott and Forster 2008), it might be informative to test the interaction between individual and collective voice and whether POs strengthen individual voice (Hirschman 1970, p.120), as well as whether policymakers listen to and act upon voice.

**Conclusion**

Patients’ organisations are skeptical about individual choice of provider (exit) as a means of meeting the needs of citizens-patients but they are convinced about the value of individual voice in achieving quality, responsive health care. Therefore, to make choice policy relevant to their agenda and meaningful to their constituents, POs reframe ideas about choice to focus on components of individual, quality care.

Although patients’ organisations are ambivalent towards choice policy and there are few examples of their impact on the policy, they are reticent to exit the policy arena and instead, most confine themselves to reactive advocacy activity. They did not use their voice to show “discontent” (Hirschman 1970, p.90) and remained responsive to policy activity in order to retain their status as a form of voice in the policy process. This demonstrates their belief in the influence of collective voice in policymaking (Taylor-Gooby 2008) and their responsibility to provide voice for citizens-patients in national policy but also their understanding of their lack of bargaining power.

The concept of exit, voice and loyalty assumes that there are “two main types of activist reactions to discontent with organisations” (Hirschman 1978, p.90). However, this oversimplifies the sophisticated relationship between organisations and consumers and disregards the range of voices attempting to influence an organisation, particularly the NHS. Whilst the concept of exit, voice and loyalty is a useful descriptive heuristic, it needs to link with emergent models of collective action, particularly in the health field. This study reinforces existing research which suggests that neither voice (individual or collective) nor exit (patient choice) works as efficiently in the NHS as Hirschman’s model suggests and that each mechanism might have other aims that do not just relate to responsiveness and quality.
References

Consumer voice? Patients’ organisations and choice policy in the English NHS.


Department of Health. 2004a. "Better information, better choices, better health: Putting information at the centre of health.". London: HMSO.


NHS Centre for Involvement. 2009. "What is the NHS Centre for involvement?" University of Warwick. Available at:


