

The consequences of marketisation for mental health services in England

Rich Moth (mothr@hope.ac.uk)

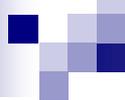
Alliances to Fight Poverty Conference

Marseille 26/06/16



Structure of presentation

- Mental health policy context in England
- New Public Management & Market reform
- Impact of market reforms: for services, practitioners and service users
- Resistance
- Recommendations
- Emergent frontiers in neoliberal policy reform

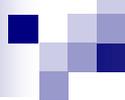


Policy context: public service reform in England

- **Macro level: Transition from Keynesian to neoliberal welfare system**
- **Meso level: health and social care service reconfiguration**
 - 1970s – 1980s Era of bureau-professionalism (Harris, 1998; 2003)
 - 1990s: Neoliberal restructuring via New Public Management (Clarke & Newman, 1997)
 - NHS & Community Care Act 1990

Mental health policy: market reform in England 1

- From 1990s: New public management (NPM) oriented reform in NHS:
 - Important strategy for integration of values and practices of market into public sector (Clarke and Newman, 1997)
 - Public sector inefficient due to an absence of market incentives
 - Undue influence of particular interest groups (eg professions)
 - Not full scale privatization but multiple 'routes to market' (Clarke, 2004)
 - However: 20 year incremental transition in NHS: internal > external markets (Pollock & Price, 2011)

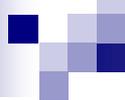


Initial NHS & social care divergence

- **Local Government:** Creation of external markets in residential & community support
- **NHS:** Transition via NPM
- **So** greater discretion in NHS than LA SSD – continuing role for bureau-professionalism in MH services
- Why? Less intensive penetration of managerialism & market: impact of risk management role (Evans, 2010)
- This began to shift in mid-2000s...

Mental health policy: market reform in England 2

- **2003: Foundation Trusts** (Provider: quasi-market body)
- **1997 – 2010: Increasing Performance management**
examples:
 - Key Social Care Performance Indicators (delegated functions)
 - Service user (SU) in receipt of review; personal budgets; employment/settled accommodation; Carer assessments/services
 - 2009: CQUIN Commissioning for Quality and Innovation (eg 2011 goals)
 - Improving SU physical health care; recovery model; smoking cessation; improving care and prescribing for dementia



Mental health policy: market reform in England 3

- **2007: Personalisation** > personal budgets
(purchasers > consumers)
- **2013:**
 - **Health & Social Care Act 2012**
 - NHS: Internal to external markets
 - **Mental Health Payment system** (formerly Payment by Results)

Impact of reform: restructuring of provision

■ Example: Mental Health Payment system (PbR)

- New funding arrangements: costed units of professional intervention replace block contracts
- Neoliberal terminology: 'tariffs', 'cluster currencies' and 'market forces factors'
- Clustering process facilitates the reconfiguring of NHS services as commodities in a market

- PbR involves allocation of mental health service users to a diagnosis-related category or 'cluster' to determine the type of care and support they receive
- 21 inc. Non-psychotic: eg anxiety/depression; Psychotic eg schizophrenia; Cognitive impairment eg dementia
- Diagnostic clusters underpinned by biomedical understandings (hybrid of medical/managerial) – **reinforces medicalised practice**

Impact of reform 2: deskilling practitioners

1. Contracts and KPIs demarcate obligations and limit discretion ('proletarianisation')

- Ruth (social worker) [bitter irony] considered recording voicemail message:
"I can't get to the phone now or see patients because of my new role as data inputter for Rio [patient record system]"

2. Less qualified staff take over non-core routine professional activities:

- Contracting out to voluntary/third sector
 - Leslie (CMHN): opportunities to engage in recovery-oriented, person-centred practice with individuals and communities were diminishing
- Deskilling/downbanding of NHS staff
 - Bill (CMHN): "if nurses are just sitting on a computer all day then they don't need experience"
 - Deleting Band 7 Senior nurses: loss of "street knowledge"

- **Strenuous welfarism** (Law & Mooney, 2007)

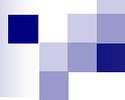
Impact of reform 3: consumerism

■ Personalisation agenda

- New vision for adult social care
- Principle of direct payments (resources directed to individuals) – extended policy of 1990s (emerged from disabled people’s movement)
- Every person allocated personal budget via Resource Allocation System (RAS)
- Reconstruct service users as *consumers* – ‘choice and control’ (Beresford 2014)
- Possible extension to NHS via personal health budgets (piloted since 2014)...

Overview of marketisation for mental health policy

- **1990s-2008:** NPM-oriented reform in NHS: markets & targets
- **Post 2008:**
 - Internal to external markets
 - Austerity as neoliberal **welfare state transformation**
 - NHS & local govt funding reductions
 - Service closure and outsourcing (Moth et al 2015)
 - NHS Bed cuts: 12% or 2100 closed since 2011, but private sector share MH inpt market increased to 29% in 2015



Impact of reform in adult social care

- **Local govt: mixed economy in the community**
 - Purchasers: care managers not social workers (budgets not relationships)
 - Providers: race to the bottom in care market
 - Pay reductions and increased insecurity for workers outside public sector
 - Work intensification

Impact of reform for service users

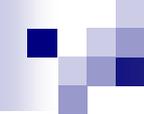
Responsibilisation

- Increased consumer responsibility:
 - Personal budgets
 - Increased charges, co-payments
- BUT Less community and social provision: 'from enforced collectivism to enforced individualism' (Roulstone and Morgan, 2009)
- Intrusive risk monitoring but less therapeutic support > reduction to medical model (and meds compliance)

Resistance

- Some small scale resistance emerging: local user-led/TU-supported campaigns against austerity cuts in social care and NHS services (Moth et al 2015)
- Junior Doctors contract strikes





Recommendations

Health and Social Care

Key principles:

1. Funding
2. 'More and better' service provision
3. For rational and democratic planning as an alternative to markets

1. Funding

- Universal health and social care provision model
 - Fund through progressive taxation
 - Free at point of access
 - No to means testing (in social care)
 - End co-payments (in health and social care)
 - Aim of 'decommodified' services:
 - Rejects internal/external market model
 - Allow citizens to maintain standard of living and realise capabilities (Esping Anderson 1990)

2. Rational & democratic planning

- Democratic accountability and transparency
 - Markets as unaccountable and undemocratic: end commercial confidentiality in public sector transactions
 - Democratic planning of provision at community level: drawing on community needs and users' experience
 - Guaranteed representation of users and mental health workers voice in decision making at local & national level
 - 'Mental wellbeing audit' of all local and national policies
- Genuine participation and collaborative co-production of services that value service users' knowledge & experience
 - Co-design: services shaped and designed by users with support from mental health worker allies
 - Co-production: organised/run by service users with professional involvement where required & preferred by users

3. 'More and better' service provision

For services

■ More

- Eliminate profit motive to boost funds for support: no to PFI; big Pharma; no outsourcing, reduce admin cost NHS market (5 to 14%)
- End Austerity cuts to social care, and individual budgets; cancel £20bn 'efficiency savings' programme
- Fund NHS inpatient beds to end out of area placements

■ Better

- Prevention via public mental health (poverty, unequal, discrim, etc)
- Invest in new 'social' approaches: Soteria; User-led crisis services; Hearing Voices approach; Open Dialogue
- Community level support: User Led community and social care services (RiTb); 'mental wealth' community resources modelled on Sure Start centres; not targeted, open to all; challenging stigma

3. 'More and better' service provision

For mental health workers

■ More

- Increase staff ratios; caseload limits (25-40/50); reduce targets and bureaucratic tasks linked to market/payment systems
- Improve pay and conditions, and end short-term contract culture for peer support and other MH workers

■ Better

- Challenge hierarchy of mental health professions, for more egalitarian inter-disciplinary teams
- New roles based on social and community model approaches: 'community and wellbeing workers'?
- Community level support: 'mental wealth' centres in communities modelled on Sure Start centres; not targeted, open to all; challenging stigma

3. 'More and better' service provision

For service users

■ More

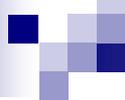
- Widen service provision/access: including availability of individual & group therapy
- No cuts to individual budgets

■ Better...

- End compulsion: abolish CTOs; for positive risk-taking
- Anti-discriminatory, culturally sensitive support
- Refocus away from over-reliance on medical model and short-term 'throughput' care pathways/stepped care

...Better

- Towards socially oriented approaches:
 - Relationship-based and person-centred practice
 - Develop peer support/ULO's & non-medicalised alternative services
 - Space for recovery & 'unrecovery' (w/o pressure from services/welfare state)
 - Community level support: 'mental wealth centres' but also housing, employment, education, green space



Emergent frontiers in neoliberal policy reform: *welfare to work*

- Health and Work Programme
- Work as ‘route to recovery’
- Co-location of employment/mental health services
- ‘Psycho-compulsion’

(Friedli and Stern 2015)

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