The consequences of marketisation for mental health services in England

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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, inequal, 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/ULOs & 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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