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Market Mechanisms and Consumer Involvement in the Delivery of Mental Health Services: A UK–US Comparison

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Both the United Kingdom and the United States are in the midst of health care reform. By focusing on services for the severely mentally ill this paper compares recent developments in managed care in the U.S. and care management in the U.K. It particularly focuses on the use of market mechanisms and consumer involvement in these reforms.

Both the United Kingdom and the United States are in the midst of health care reform. A critical issue in these reforms is the increased emphasis on market economics in the delivery of health and social services. Managed care, managed competition and a mixed service economy are but a few of the terms being used to describe the current reforms. The intent of this article is to: identify the assumptions underlying the introduction of market mechanisms in health and social care; review some of the evidence and research regarding these assumptions; discuss the unique nature of social markets; and explore means of moving forward. The article does focus primarily on how these developments are unfolding in the delivery of services for persons who have a serious mental illness.

Market Mechanisms in the Human Services

Rationale for Social Markets

Similar arguments have been used in both the U.S. and Britain to support market mechanisms in the delivery of health and social services. Managed competition in the U.S and the mixed economy in the U.K. are the two terms which best describe the market mechanisms being promoted in these two countries. It is assumed that

independent providers would overcome excessive bureaucracy, remove political constraints, make the system more responsive to consumer needs, make providers innovative and responsive and increase quality and efficiency (Propper, 1992).

Central features of these mechanisms in the U.S. include contractual arrangements with selected providers to deliver a set of services at a negotiated price, financial incentives to guide patients to providers within the plan, and ongoing accountability through quality assurance and utilization review (Arnould, Rich, White & Copeland, 1993). Mayo (1994), in an attempt to unravel the myths surrounding the mixed economy, identifies the most frequently asserted benefits of market mechanisms.

1. The private sector and/or the voluntary sector can be more cost effective than public-sector provision.
2. Increasing the mix of provision within the mixed economy of care increases consumer/client choice.
3. State provision is inherently bureaucratic, whereas private and/or voluntary provision can be less bureaucratic and paternalistic, which allows for greater innovation and flexibility.
4. The welfare state has reproduced patterns of inequality in terms of race and gender. Alternative forms of provision have therefore been essential as part of strategies to combat these structured inequalities.
5. More generally, voluntary welfare structures outside state provision, and self-help schemes, in particular, have a role in wider political strategies to promote active participation and democracy. (p. 27).

Are They Working?

Paton (1994), in a recent book on competition and planning in the National Health Service in Britain, asserts that the adoption of the ideas of provider markets and the internal market draws on a misguided perception that US health care is moving towards efficient supply-side competition. Further he argues that competition is an American response, and only a partial one, to an American problem. He claims that there is no case for arguing that British planning has failed and that competitive markets are needed in Britain.

A few of the lessons for the U.K. from the American experience are that competition does not occur automatically, that transactions in the market can become bureaucratic and expensive and that very formal purchasing processes are likely to lead to the exclusion of small suppliers (Flynn & Hurley, 1994). Even though we have recently witnessed the demise of President Clinton's Health Security Plan this has not stopped the proliferation of managed care systems for the mentally ill in a growing number of States. Many have decided not to wait for Federal reform primarily because cost containment is a top priority. At least 35 States already have some form of capitated payment system for Medicaid clients with severe mental illness (McFarland, 1994). While Health Maintenance Organizations (HMO's) are taking up contracts to provide services to this population, numerous criticisms to this approach have been voiced. Difficulties include: unrealistic limits on number of units of service; a reversion to a more medically-driven model of care; lack of emphasis on community-based outreach and psychosocial rehabilitation; little information on efficacy of interventions; and the danger of lowest-bid providers. Public sector managed care involves the identification and balancing of a wide range of competing objectives. Hoge, Davidson, Griffith, Sledge, and Howenstine (1994) suggest that efforts to provide accessible, comprehensive, continuous, and effective services must recognize the scarcity of resources and the need for cost efficiency. A new generation of studies is needed to inform us about the most effective ways of organizing managed care for the seriously mentally ill.

In terms of creating a mixed economy of care in Britain the record to date has been very uneven. The development of a mixed economy that produces the cost reductions, quality improvements and expansion of choice as laid out in government policy depends upon an adequate number and range of alternative suppliers of service (Wistow, Knapp, Hardy & Allen, 1994). Factors which have limited this development include too few suppliers, underdeveloped suppliers, barriers to entry, lack of capability or willingness to accept expanded contracts and the diversity of needed services.

Mayo (1994) systematically reviews each of the previously stated assumptions underlying market-driven reforms. Her

major conclusions, many of which are collaborated by other investigators, include that: the non-statutory sector is not necessarily cheaper or more cost effective; it does not provide greater consumer choice; public bureaucracies can provide good quality services; racism and sexism are by no means confined to the public sector; and voluntary organizations are not necessarily more democratic than their public sector counterparts.

Social Care is Different

Some authors suggest that markets in health and social care do not function like markets in the business sector (Flynn & Hurley, 1994). Le Grand and Bartlett (1994) call them quasi-markets since they do differ significantly from traditional markets in both demand and supply characteristics. Not all organizations in social markets are out to maximize profits, most are not privately owned and in most cases it is not the direct user who exercises the choices regarding purchasing decisions (Le Grand & Bartlett, 1994).

It should also be noted that, in terms of the implementation of quasi-markets, there are differences between the health and social care sectors (Wistow, Knapp, Hardy, & Allen, 1994). Social care, seen from a commodities perspective has many characteristics which make it incompatible with an unfettered unregulated market. In the area of services for the mentally ill there are often episodes of unpredicted service need which will not wait for the negotiation or renewal of contracts. Blanket contracts often homogenize rather than individualize service users. On the other hand spot(individualized) contracts do not give providers the funding base that they need to survive. In rural areas of the country one is often fortunate to find one agency willing to provide a needed service.

Many of these issues underpin the resistance to social care market development. Some of the reservations identified by local authorities in the U.K. include the uncertainty of the policy with particular reference to the structure of local government and continued funding; the ideological belief that social care is different and does not lend itself easily to a market mentality; pride in public sector provision; and the limited potential of providers outside the public sector (PSSRU, 1992). Many authorities still believe that the organizational split between purchasers and providers

was an artificial division of work and argue that there should not be a break between assessment of need, provision of service and monitoring and reassessment of need (Flynn & Hurley, 1994). The efforts to develop social care markets in local authorities in the U.K. have been very uneven from virtually none to a few who have done excellent work and have a diverse array of services for their users. Unfortunately the latter are the exception rather than the norm.

In the U.S. the development of various systems of managed care, both public and private are underway and heated debates are occurring both at conferences and in the professional literature regarding the efficacy of these initiatives. In an effort to develop the best possible design for these programs, the Center for Mental Health Services of the Department of Health and Human Services and the National Association of Case Management recently hosted a think tank on managed care for the seriously mentally ill.

Moving Forward

Revisiting the Mission

The recent reforms in community care in the U.K. and managed care in the U.S. have precipitated a so-called cascade of change. On the one hand these initiatives might represent what the Chinese call the "let a thousand flowers bloom approach". Other observers comment that we have moved to an even more chaotic, out of control non-system of care. Still others accuse the central governments of both countries of passing the buck (pound) to lower levels of governance and neglecting their leadership responsibilities. Which ever position one subscribes to it is quite clear that the current mission to provide cost-effective care for the seriously mentally ill will be very difficult to achieve. Critics (Means & Smith, 1994; Seedhouse, 1994; Paton, 1994) have pointed out that the objectives are too ambitious, subject to interest group interpretation, not necessarily mutually achievable, and under-resourced. One could even argue that the costs involved to develop social markets, negotiate and monitor contracts, and facilitate significant and meaningful user involvement is much more expensive than providing good quality public sector services. A major challenge then is to revisit and reality test the mission of

community care/managed care—what is feasible, desirable and acceptable within the currently available resources?

An Holistic Approach to Planning

To encourage collaboration and promote system coherence a systems approach to planning is essential (Turner-Crowson, 1993). In the U.K. local authorities, in collaboration with users, must map out the needs of their area, assess existing and potential (formal and informal) resources, identify priority groups for service and structure their service systems to respond to these needs. This has happened in a number of areas but is not yet common practice. More typically planning and development has been incremental and piecemeal. A critical impediment has been the underresourcing of the planning and market development functions within local authorities. In the area of mental health, recent work by the Mental Health Task Force (1994) is moving in this direction. They have specified the target group as the seriously mentally ill and identified the critical components and functions of local systems of support for this population. It is important to underscore, however, that no one model is appropriate for all areas. It must be tailored to take into account geographical, population, cultural, gender and other contextual factors. Some of the same criticisms prevail in the U.S. scene—many States are involved in a variety of approaches including public sector managed care, private sector carveouts, capitation systems etc. While these are steps in the right direction they too are characterized as insufficiently systemic and do not address other sectors of provision such as income security, housing and vocational rehabilitation.

Market Development

Given the assumption that the emphasis on social care markets will continue, more systematic development and creativity are essential. Market development plans within overall Community Care Plans/State Mental Health Plans are critical. Based on thorough needs and resources assessments, these plans should specify the what, when and how of the mixed economy of care for each area. In the area of contracting various options such as long-term, standard, incentive, and volume-cost are available. These mechanisms need to be used selectively and creatively to

ensure a good quality social care market infrastructure yet sufficient individualization in provision of care—a delicate balancing act! Joint purchasing, decentralized budgets, better information systems and an enhanced community care planning process are central to overall improvement (Wistow, Knapp, Hardy & Allen, 1994). Again one model of market development is not possible, each plan must recognize the limitations of market development in their area by understanding the unique community context within which they provide services. The market mechanism to be used in each circumstance then needs to be tailored to these unique contexts.

Consumer/User Involvement

A critical issue in these reforms is the promotion of user involvement in all aspects of service delivery. The Community Care legislation in Britain places particular emphasis on the involvement of users in the planning, purchasing and provisioning of services. User involvement in the development of social care markets, however, has been very limited. Flynn and Hurley (1994) found that the choice of services had not been improved by the process of contracting, that services were either designed by the purchasers or the providers, with little user involvement and that services were managed by the providers and monitored by the purchasers, with little user control.

While the overall picture is not good, there are a few examples of genuine and significant user involvement such as the Wiltshire Community Care User Involvement Network and the Newcastle Mental Health Consumer Group (Ramon & Sayce, 1993). These groups are not only significantly involved in the purchasing function of services but throughout the care management planning process. This continuing involvement maximizes the quality of their input during the market development and purchasing processes. User forums and evaluations have also provided additional opportunities for input. The degree of user choice and control can also be articulated in contracts.

In the transition to managed care in the United States the has generally been little involvement of consumers, where it has happened is in locations where there was already an infrastructure of

consumer involvement. This includes involvement in Planning Councils (PL 99-660), National Organizations like NAMI, Protection and Advocacy Offices, State and National self-help groups and a variety of agency-based mechanisms for consumer input. We have also seen the growth of consumer-run services such as Mind Empowered in Portland and Mindstar in San Diego. Maximizing consumer involvement in these reforms requires action on a number of fronts. Individualized capitation (spot contracts), flexible funding, more significant participation in Councils and Commissions, consumer-run services, accreditation standards for consumer involvement and innovative approaches for rural areas are only a few of the initiatives that might further consumer involvement in the reform agenda. Finally, users need to be resourced so that they can be significantly and continually involved in the creation and delivery of appropriate services. Their involvement may provide the acid test for markets in the field of social care.

Lessons Learned

What then are the lessons to be learned from this cursory review of the experiences of the U.S and Britain in their efforts to control escalating costs in the delivery of care? Firstly we must be clear about both the direct and indirect objectives of such initiatives. While these reforms are often couched in consumer-responsive language the bottom line is cost reduction. In both countries the lack of resources will impede the range and availability of community-based services and hence we have an exploitation of a community-based philosophy of care to further the cost cutting agenda. Secondly, what is good for one country is not necessarily transferable to another. Transfers must be tailored to the unique context, culture and history of the host country. Thirdly, the legislative mandate in the U.K. on consumer involvement, while subject to interpretation, appears to be stronger than that provided in the U.S. Part of it however may be the swiftness, in the U.S. with which managed care schemes are being put in place while others would argue that the current mechanisms for consumer involvement are themselves ineffective.

Finally, in both countries much more research and evaluation is essential to inform policy debates and improve the quality of

these initiatives. I believe the U.S. has much to learn from the innovative consumer involvement projects in the U.K. particularly in the planning, purchasing and provision of care. Britain on the other hand will find the results of capitation approaches to managed care in the U.S. of use in the future development of their system.

The rapidly growing interest in managed care or care management as it is called in the U.K. has produced some positive outcomes. It is forcing us to critically think about how we provide services and how we can provide the best quality of services to the most people within resource constraints. It also helps workers in the system to realize the importance of documenting what works well for those we serve. The practice wisdom gained through years of providing case management services to the severely mentally ill needs to be captured and utilized in the development of systems of managed care. Policy and service decisions are frequently made by those farthest from the realities of the everyday lives of the severely mentally ill. Even more serious is the charge that consumers of service have had little input into the rapidly developing systems of managed care. Consumers need to be resourced so that they can be significantly and continually involved in the creation and delivery of appropriate services (Fisher, 1994).

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