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Publication details

Post-print of: Holdsworth, L, Sweeney, D & Pollard, D 2004, 'Welfare, neo-liberalism, and the tough business of being a consumer', *Australasian Journal of Business and Social Inquiry*, vol. 2, no. 1, pp. 18-28.

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Welfare, neo-liberalism, and the tough business of being a consumer

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Keywords: Mental health, consumer, neo-liberalism, consumerism, labelling

Abstract

In this article we are primarily concerned with the disparity between the 'mental health consumer' label which carries implications of consumer power and consumer rights, and the reality underlying consumerist societies which presupposes a level of choice and spending power. The consumer label, while attempting to free the patient/client from an unequal relationship to her or his doctor or health care worker, has merely traded one inequity for another. For persons with a chronic mental illness who are either unemployed and/or welfare dependent, the consumer label has potentially negative consequences. Not only does it fail to address the sometimes involuntary nature of mental healthcare, but within the current political climate, the neo-liberalist user-pays philosophy is imposed onto a group whose spending power and freedom of choice is already heavily compromised.

Introduction

In the early 1970s, the Australian Consumer Council and the Australian Federation of Consumer Organisations were among the first groups to put the 'health consumer'

concept into effect. In their effort to challenge the power base within the structure of the health system, the group for patient advocacy sought greater social equality and democratic control of health care institutions. There was increasing resistance to the doctor's privilege, the patient's passivity, and to the dominant themes within the politics of the provision of health care. Then, in 1991, the Human Rights and Equal Opportunity Commission (HREOC) undertook a national inquiry (The Burdekin Inquiry) into mental health practice. 'This inquiry chose to use the term "consumer" to describe all of the people deemed to have a mental illness' (Gosden 1997 [online]).

The use of 'consumer' aims to give power to the person seeking a health outcome, purportedly placing them at the centre of the action with the focus on them rather than the health provider. Implicit in this description is the notion that all consumers are 'willing participants in the mental health service industry' (Gosden 1997 [online].

As citizens living in an increasingly consumer oriented society, we are often labelled as consumers. Consumers have purchasing power, are free and able purchasers of goods and services whose rights are protected through regulations, standards and laws (Meagher 2002, p.107). However, this is predicated on the notion that consumer power is inexorably tied to spending power, the reverse of which implies that 'those who have little or no money have little or no power' (Tomes 1999, p.46). Without power, the term 'consumer' is left wanting. In a user-pays oriented society, such a term has the potential to discriminate against those whose experience is often one of chronic economic hardship. Thus, while a tone of respect is implicit in the language of consumer rights, it is a respect founded on the consumer's ability to be a full participant within capitalist society.

Defining consumer participation as the buying (or selling) of any goods or services, describes most, if not all, members of a society as 'users' or 'consumers' given that consumption includes necessities such as food, clothing and housing. When considered within this framework, recipients of mental healthcare services are accurately portrayed as consumers in that 'user' involvement constitutes a valid concept of 'consumer.' However, the categorisation of all service-users as consumers fails to recognise '...a considerable percentage of people [who] are effectively disenfranchised from consumer culture' (Miles 1998, p.148).

The consumer term has, terminologically speaking, replaced us as citizens in much the same way as politicians and economists refer to societies as economies. In the new consumer culture individuals are renamed to comply, whether or not they have the means. This all but ignores the 'unfulfilled consumers, whose resources do not measure up to their desires' (Bauman 1998, p.75). Resources are embedded within consumerism as freedom of choice, yet this too is predicated on the assumption that free choice is even possible. In western (some would say middle-class) societies, the freedom to choose is directly linked to income level, rendering some low income earners virtually choiceless. Of all the social barriers that people with mental health issues face, lack of economic self-sufficiency and reliance on welfare remains paramount.

> In modern society, money has become the currency for things tangible and intangible. Money can buy independence, influence and even self-esteem. Without the means to become economically self-sufficient, an individual with disabilities will still be subject to the welfare of the social services system, thus losing a measure of personal control (Wappett 2002, p.122).

Economic hardship can impact in a variety of ways. For persons with a mental illness, who because of their ill health are unable to gain or maintain employment, economic self-sufficiency is unattainable. Instead these individuals face a reduced standard of living compounded by negative attitudes about their situation (Sherry 2002, p.4). This raises the question of whether a materialistic environment is hostile to those members of society in which whose ability to participate is impaired or disadvantaged? It certainly appears particularly problematic to burden persons who have a mental illness, especially those who are unemployed and/or welfare dependant, with a label rooted in materialism. While the positive traits of the 'consumer' term attempt to empower the patient/client, the conceptual shift seems short-sighted, especially given the vulnerability of consumerism to the pressures of market-driven healthcare (Tomes 1999, p.47).

Language

> Language is the cornerstone of every culture. It is the chief vehicle by which people communicate ideas, information, attitudes, and emotions to one another, and it is the principal means by which human beings create culture and transmit it from one generation to the next (Hughes, Kroehler & Vander Zanden 2002, p.46).

Language is fundamental to our understanding of relationships. Foucault (1977, cited in Haralambos et al. 1996, p. 159) identified discourse as a way of talking about and organising knowledge. As such, the discourse about the 'mental health consumer', for example, can also be seen as a way of classifying and regulating people. The shift from 'patient' to 'client' dramatically and purposefully altered the way power was weighted within the traditional doctor/patient relationship. The transition to 'consumer' was intended to liberate the relationship altogether, breaking entirely from the traditional paternalistic model.

The problem is that the word ‘consumer’ is hardly neutral. According to Herxheimer and Goodare (1999, p.3) it carries ‘commercial overtones...and connotations of consumerism’ while for Corrigan (1995, p.10) it presents a complete break from the fixed idea of traditional consumption where needs were finite. Instead, he says, ‘the modern consumer considers with alarm anyone who does not want to consume more and more, who does not seem to be interested in new wants and desires’. The discourse associated with the labelling of those accessing health care professionals as ‘consumer’ therefore raises issues within an individualist, consumerist society.

Labelling, neo-liberalism, and the consumer

> Neo-liberalism is underpinned by beliefs in the efficacy of the free market and the adoption of policies that prioritise deregulation, foreign debt reduction, privatisation of the public sector...and a (new) orthodoxy of individual responsibility and the “emergency” safety net - thus replacing collective provision through a more residualist welfare state (Hancock 1999, p.5).

In this section we examine the interrelationship between labelling, the neo-liberal perspective, and the term ‘consumer.’ Our specific concern is the possible intrusion of the neo-liberal mindset onto what is essentially the ‘social nature of identity’ (Billington, Hockey and Strawbridge 1998, p.56). By locating the discourse of consumerism within the broader political framework, we are able to argue against the neo-liberalist view and its positioning of welfare-dependent groups, with the aim of drawing attention to the potentially negative consequences that the consumer label imposes onto persons with a mental illness.

Labelling is often the response by those in power to categorise the powerless. Irvine (2002, p.32) argues that the concept of the health consumer is 'integral to the exercise of power and instrumental to the operation of power relationships that shape the way things look and state what things mean.' Therefore it is essential to uncover the apparently hidden agenda of the adoption of the term 'consumer' for those requiring health care services as, in a power relations theory, conflict between various groups is seen as inevitable (Sargent 1991).

Persons with a mental health problem are defined by their labels, actually *re*defined by the medical label in such a way that the label itself 'functions as a master status that overshadows all other aspects of the person's life' (Schaefer 2002, p.395). For example, a person with a mental illness such as schizophrenia is labelled schizophrenic, often regardless of whether or not treatment is being sought, thus rendering the label itself to have the effect of 'lock[ing] the individual into outsider status' (Hughes et al. 2002, p.147).

Labels render persons 'subject to the interpretation by others' (Schaefer 2002, p.395). Labelling people as 'disabled' reflects the discourse - uncritically accepted by policy makers - which was created by the medical approach of identifying people. The creation of a discourse of medical expertise 'disempowers disabled people by allocating to them the role of patient, client or consumer' (Sherry 2002, p.4). Labelling theory evolved as a method of explaining society's reaction to deviance. Essentially, something is deviant contingent on the label of deviance being successfully applied (van Krieken et al 2000, p.442). In a sense, by attempting to expose the deviance within the term 'consumer' we are also responsible for creating

the deviance of the label. The question whether the consumer label is intrinsically deviant, is wholly dependent on our frame of reference, which in this case is the neo-liberal perspective.

The adoption of a neo-liberal social policy in the 1970s and 1980s saw the introduction, in many western societies, of a more minimalist approach to social services such as welfare and health care within a consumerist rhetoric (MacGregor 1999). Neo-liberalist initiatives are typified by 'free market policies that encourage private enterprise and consumer choice and reward personal responsibility and entrepreneurial initiative...' (McChesney 1999, p.1). Consumerism is the dominant paradigm of a society concerned with acquisitiveness. But where does consumerism and neo-liberalism leave the most marginalised in society when it comes to accessing services?

Andrews and Jennings (1999, p.8) state that 'traditionally the role of the government in providing services starts with an assumption that citizens have a "right" to services, because it is the responsibility of government to provide for its citizens.' However, because neo-liberals view citizens primarily as rational consumers of public goods, Voet (1998, p.10) 'question[s] whether neo-liberalism really has a concept of citizenship.' Neo-liberalism places emphasis on the individual and mutual responsibilities rather than on rights, and therefore fails to distinguish between our roles as consumers and citizens.

Campbell (1994, p.7) notes that 'health consumerism is based on the assumption that persons who seek health services are consumers just as are those who seek other types

of services.' Carter (1996, p.64) claims that the term suggests a variety of strategies for participation at different levels, such as decision making, defining needs and evaluating outcomes, as well as being an open accountable system. However, Hogg (1999, p.169) believes that the patient-as-consumer is in fact a myth and states that the 'consumer model does not fit well into health care.' The term 'consumer' fails to highlight inequalities between various social groups because patients, unlike consumers, do not have any significant power when it comes to influencing decisions made in relation to health care. Similarly, Irvine (2002, p.31) asserts that the application of consumerism for those receiving health services is not appropriate 'because it fails to describe accurately the actual behaviour of patients in the concrete setting of the hospital, the clinic or the practitioner's surgery.' In other words, 'users [of health care services] have not become genuine consumers with purchasing power' (Epstein and Rechter 1999, p.23)

The discourse associated with neo-liberalism, and in particular the word 'consumer', sets the scene for relationships between policy makers, medical practitioners, and those receiving health services. The relationship is one of power - between the various participants of health care - based on individualistic policies (Irvine 2002, p.32). The 'Anglo' countries, in particular, have embraced the individualist policies of neo-liberalism (Saunders 2001, p.30). In Australia, neo-liberal economic policies were implemented by Labor governments under the Hawke leadership between 1983-1991, continued by Keating from 1991-1996, and are evident in the present Howard led Coalition government's agenda (Fairbrother, Svensen and Teicher 1997).

In a study of fifty countries, Geert Hofstede found that the most individualistic country is America, followed by Australia, then England and Canada (Saunders 2001, p.32). It is this individualism that helps explain contemporary welfare reform and changes to health care. Within a consumerist framework, concepts such as economic rationalism, consumerism, and user-pays, are ideologies espoused by this perspective. Voet (1998) notes neo-liberalism is particularly opposed to the welfare state and supports the free market. Countries that have embraced welfare reform are those where the notion of self-reliance, individualism, and personal responsibility are the strongest. The neo-liberal view that money should be spent sparingly on public resources and services has become accepted as the conventional wisdom and is pervasive of much of the thinking on welfare (MacGregor 1999, p.97).

The adoption of neo-liberalist ideals, including privatisation and individualisation, has destroyed much of the existing social infrastructure. A style of expenditure cutting, ultimately geared towards a less compassionate approach to dealing with the most marginalised groups in society, prompted Mackay (2003, p.32) to ask whether 'the user-pays philosophy [is] killing off our sense of mutual obligation?'

This approach to social policy formation is evidenced by the term 'consumer.' The term conjures up notions of *using up* and *absorbing* available resources. It seriously reflects the preoccupation of neo-liberalism with consumerism and the acquisition of goods, and neglects to address society's caring role. In addition, neo-liberalism fails to distinguish the differing interests amongst social groups, especially in relation to power. Instead of the original notion of the term 'consumer' (as a way of balancing power between the decision makers, health practitioners and those accessing services)

hegemonic undertones are clearly evident. By adopting the language of those seeking health care services, power structures become blurred. In order to win ideological consent to rule, officials and political decision makers take up the language of the governed and 'appropriate progressive political ideas, strategically manipulating or altering them in order to produce a "shared" framework that may be more apparent than real' (Irvine 2002, p.36).

Relations between social groups can be seen as relations of power (Sargent 1991). The dominant ideology can therefore be seen to give only a partial view of society and serves to legitimate and justify the status quo. If the ruling class manages to maintain its control by gaining the approval and consent of members of society, then it has achieved hegemony (Gramsci 1971 cited in Haralambos et al 1996). Hegemony refers to the achievement of political stability by persuading members of society to accept the political and moral values and beliefs of the ruling class (Haralambos et al 1996, p.128).

> The capitalist class seeks to persuade society not only to accept the policies it advocates but also the ethos, the values and the goals which are its own, the economic system of which forms the central part, the 'way of life' which is the core of its being (Miliband cited in Haralambos et al 1996, p. 124).

In regards to consumerism, the hegemonic acceptance of the term 'consumer' has enabled the government to impose its beliefs regarding consumerism on the majority, by justifying and maintaining its dominant position with the consent of those being ruled. It is therefore important not to take the seemingly innocent acceptance by policy makers, of an apparently inclusive and empowering term as 'consumer,' at face value. Issues of power are paramount here. Society has been persuaded to accept the political and moral values of those in power.

In order to gain acceptance by the population, the beliefs of the powerful must be internalised by the majority of the population (Gramsci 1971 cited in Haralambos et al. 1996). The acceptance of consumerism and user-pays has been achieved through neo-liberal policies of a more residualist approach to social services such as health and welfare. Clarke (1997, p.78) claims that this approach 'aims not only to break up the old institutional attachments but also to create new forms of articulation between the citizen-as-consumer and the state.'

Consumerist policies have a particular impact on those who do not have adequate access to material goods, although many people with mental health issues see their problems as both financial and social. Factors include being poor, being unable to work or participate in other aspects of society (Bowl 2002, p.111). Mulvany (cited in Sherry 2002, p.4) points out that the complexity and variety of the social limitations experienced by people with disabilities (and we are assuming this is broad enough to include persons with mental illness) means the experience is often one of chronic economic hardship, unemployment, and relationship breakdown. This is compounded by the labelling of people with mental health problems as deviant, and the general classification of welfare recipients as undeserving. Both are reflective of a society that has become less compassionate towards those most disadvantaged and in need of our compassion.

The Health System and Class

From a conflict perspective it is necessary to understand this situation regarding those who are disadvantaged and marginalised as a determinant of inequality <u>within</u>

capitalism. While Foucault (1977, cited in Haralambos et al. 1996, p.160) believed that 'medical power is linked to the forms of knowledge produced by medicine, and these are used in turn to control individuals and populations', a conflict approach goes further and argues that it is necessary to understand the role of the health care system in relation to the needs of capitalism.

It is not only required that a critique of the medical system be carried out, but also that the entire capitalist, user pays, consumerist system be questioned through applying social justice principles. Connell (1988a, p.215, cited in Haralambos et al. 1996, p.161) points out that a social justice approach, by 'prioritising the interests of the least advantaged [and] rethinking the problem of health and class "from below" leads to rather different principles for the operation of the health system'. The needs of the disadvantaged must also be considered rather than concentrating solely on the needs of the ruling class. As Hogg (1999, p.174) notes, 'the myth of the health "consumer" diverts attention away from inequalities in health among different groups in the community'.

Conclusion

Even though the term 'consumer' was adopted ostensibly as a means of empowerment, it can in fact be seen as a way of regulating the mentally ill. To label those with mental illness within the individualistic, neo-liberalist rhetoric of consumerism is both inappropriate and damaging. Those with a mental illness need to be shown compassion, and the system in which a term such as 'consumer' is applied to those without genuine consumer power appears unjust. As Tomes (1999) notes, this conceptual shift is short-sighted and based on the notion of spending power.

Labelling persons accessing health services as ‘consumers’ blurs power structures and gives a false impression of choice and control. This labelling is fundamental to the shaping of power relationships (Irvine 2002).

The label of ‘consumer’ is rooted in materialism. Policies towards health care are market driven and encourage private enterprise (McChesney 1999). Adopting the consumerist rhetoric towards those with a mental illness reflects the neo-liberalist approach to welfare within the paradigm of personal responsibility, while espousing a minimalist approach to social services such as welfare and health care (MacGregor 1999). However, people experiencing mental illness often live in chronic economic hardship, and in a consumerist society with emphasis on spending power, those without money have little power. Priority needs to be given to improve the life chances of the least advantaged who are less able to compete in a capitalist society. In a society overly concerned with the acquisition of wealth and where money and consumerism equates with independence and power, the ‘health consumer’ label effectively discriminates against a group whose spending power is, at worst, ineffectual.

The notion of ‘patient’ is akin to passivity and raises issues of medical paternalism whilst ‘Client’ is used to describe those seeking the services of professionals in a wide range of services, however the currently used label ‘health consumer’, with its notion of ‘empowerment’ and focus on participation is misleading. The term ‘consumer’ has negative connotations when applied to those seeking the services of health professionals who are without the capacity to exercise spending power (Irvine 2002). In addition, the term ignores the humanness of those with mental illness and merely

allocates them a role. The term ‘consumer’ impacts on all of us no matter what our position. The hegemonic overtones of the language of capitalism alert us to what it means to be a ‘consumer’ rather than a ‘citizen’ within neo-liberalist ideology and it is our recommendation that a more appropriate term be sought.

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