This chapter explores the welfare state system in the UK. We critically review its historiography, major institutions and contemporary issues relating to its sustainability. We draw out one feature of the welfare state via an in-depth case study: its mental health care system focusing from the legacy of Thatcherism to the present.

From the 1970s onwards the post–World War II welfare state in the UK was thrown into question. The final quarter of the 20th century had often been captured as the epoch of the crisis of the welfare state (Powell, 2014). The guarantees of the welfare state, long-term growth and affluence, it was argued, had led to a permissiveness, overburdened democracy and inflationary tendencies associated with Keynesian demand management (Phillipson, 1998).

Since the 1980s keywords in the political debate became “vulnerability,” “fiscal overload,” “ungovernability” and “unsustainability” (Phillipson, 2013). In the 1990s, with levels of unemployment hovering around 10 percent in a majority of European political economies including the UK, the “prospect for survival” of the welfare state was recognized as problematic (Cook et al., 2015).

The reason is very much related to welfare reforms tied to neoliberalism. For example, through the 1980s and into the 1990s, the UK’s health care system endured welfare reforms inspired by a wave of neoliberalism that intoxicated policy makers and their advisors.

This “health reform” era saw health care systems subject to radical change. The preceding post-war era was marked by welfare policies intended to build civil society and expand service coverage, for example, by building hospitals (National Health Service, or NHS) and creating government infrastructure to administer public health care funding and service delivery. Such arrangements tended to include central planning and administration of health systems, and leadership at the service delivery level by medical and other health professionals within the “welfare state.”

We begin our discussion by contextualizing the emergence and consolidation of the welfare state in Great Britain through the political drive of William Beveridge.
Beveridge and British welfare state system

The welfare state is the largest institution of government. The ethos of the welfare state was motivated by the findings of the Beveridge Report (1942), which argued for a support system for the vulnerable groups in society (Phillipson, 1998). Powell et al. (2002: 29) state:

The Beveridge Report of 1942 is often seen as a historical moment of wartime reconstruction and the blueprint of the welfare state.

Hence, the defining feature of the post-war welfare state is of social protection, which came to be firmly anchored on the explicit normative commitment to grant social rights to citizens in areas of human need (Phillipson, 2013). This implied the expansion of mass education as an instrument for equal opportunities, access to high quality health care for everyone, together with the introduction of a universal right to real income, in the words T.H. Marshall’s seminal work, *Citizenship and Social Class* (1950), “not proportionate to the market value of the claimant.” Social citizenship held out a promise of the enlargement, enrichment and equalization of people’s “life chances” (Marshall, 1950: 110, quoted in Powell, 2014: 44).

Marshall thus defined social welfare as the use of democratic political power to supersede, supplement or modify operations of the economic system in order to achieve results which the economic system would not achieve of its own (Powell, 2014). In his first report, *Social Insurance and Allied Services*, Lord Beveridge saw “freedom from want” to the be the pivotal objective of the welfare state (Phillipson, 2013). In his 1945 *Full Employment in a Free Society*, however, Beveridge came to view employment, active participation or inclusion in productive work as a key function of being an accepted part of a larger collective identity (Phillipson, 2013). In Beveridge’s participatory view on full employment, social citizenship went beyond the right to a decent income, to include the right to live from labor, to combine their income with the recognition of a social function.

It has been argued by the main political parties that the welfare state must be “free at the point of delivery” (Phillipson, 2013: 43). The Beveridge Report of 1942 proposed a system of national insurance, based on three “assumptions”: family allowances, a national health service and full employment (Walker, 1996). This became a major political issue, with both Labour and Conservative parties committed to its introduction (Cook et al., 2015).

During the war, the coalition government also committed itself to full employment through Keynesian economics, pensions, free universal secondary education and the introduction of family allowances (Hills, 1993). The Labour Government was elected in 1945, and introduced three key Acts:

1. The 1946 National Insurance Act, which implemented the Beveridge scheme for social security;
2. The National Health Service Act 1946;
3. The 1948 National Assistance Act, which abolished the Poor Law while making provision for welfare services (Phillipson, 1998).

These acts were timed to come into force on the same day, June 7, 1948. The key elements of the “welfare state” were understood as being social security, health, housing, education, and welfare and children (the “personal social services”). Contemporary arguments emphasized the inter-related nature of these services and the importance of each for the others. However, the administrative division between services was reinforced by reactions against the unifying and
all-embracing nature of the Poor Law, which led to a strong distinction being made between income maintenance, health and welfare services (Hills, 1993).

The welfare state was not intended to respond to poverty; that was what the Poor Law had done (Phillipson, 1998). The main purpose was to encourage the provision of the social services on the same basis as the public services – roads, libraries and so forth – an institutional model of welfare (Hills, 1993).

In 1944, the government formally committed itself to the maintenance of full employment through Keynesian welfare policies. The economy was seen as vulnerable to the trade cycle, fluctuations in economic development which arose because different sectors of industry were out of phase with each other (Cook and Halsall, 2011). To achieve stable growth, governments had to encourage spending during slumps and discourage it during economic booms.

This stabilization was not particularly successful. In part, this was because governments lacked the ability to respond precisely and at the appropriate times; in part, too, no government wished to damp down a boom. The problem was known in the 1950s as “stop go.” However, virtually full employment was maintained, with little inflation, throughout the period when Keynesian welfare policies were operated (Phillipson, 1998).

Perhaps more important, certain problems in the British economy were obvious by the late 1950s. Britain was growing more slowly than any of its competitors. It was over-reliant on the “old staples” – coal, cotton and heavy engineering which were inefficient, outdated and producing goods with little appeal to consumers. The Wilson government, 1964–1970, attempted to change the balance through economic planning (Hills, 1993). The Heath government, beginning in 1970, proposed a program which contained many of the elements of what is now called “Thatcherism,” including a refusal to support industries that were labeled as “lame ducks” (Hills, 1993).

However, convinced that traditional Keynesianism did not work, the government attempted a “rush for growth” and flooded the economy with money. The conventional Keynesian analysis suggested that this would stimulate the economy to some degree, but production would not be able to keep up, causing inflation, and the money would be spent abroad on consumer goods. Without the world oil crisis, there would still have been the largest balance of payments deficit to that date (Phillipson, 1998).

The mid-1970s were consequently marked by retrenchment and “cuts,” although many were cuts in expected growth rather than in actual expenditure (Hills, 1993). The government apparatus for control, devised during a period of expansion, was turned to the reduction of expenditure. The Conservative government elected in 1979 undertook to deal with Britain’s fundamental economic problem – its over-reliance on outdated industry. This was to be done through the market, and the decision was taken to take measures which exacerbated the depression, rather than counter-cyclical measures. Manufacturing industry bore the brunt, with massive unemployment as a direct result. Unemployment more than tripled, from 1 million to over 3 million on the official figures, and there was a major shift out of the manufacturing industries. Many local economies have never recovered (Cook et al., 2015).

The period of the 1950s and 1960s also coincided with recognition of the importance of long-term demographic change, with a range of associated issues now placed within the framework of what came to be viewed as a “welfare state for older people” (Phillipson, 1998). In the post-war period or up until the economic crisis of the early 1970s, old age was constructed through the pathways provided by organized capitalism. Modernity created the conditions, through social reforms, for the creation of a “standardized” old age, the end phase of a structured life course divided into periods of education, work and leisure. Phillipson (1998) makes the point that the story of aging over the past decade or so
has unquestionably been the unraveling of the welfare institutions closely associated with modernity, and not least those intimately connected with the lives of older people. One way of understanding social changes since the early 1970s has been presented by Young (1999: 6) in the following way:

The transition from modernity to late modernity can be seen as a movement from an inclusive to an exclusive society. That is from a society whose accent was on assimilation and incorporation to one that separates and excludes. This erosion of the inclusive world . . . involved processes of disaggregation both in the sphere of community (the rise of individualism) and the sphere of work (transformation of . . . labour markets). Both processes are the result of market forces and their transformation by the human actors involved.

Coupled with this, the movement from “inclusion” to “exclusion” from the early 1970s posed a major challenge to different social groups in the British welfare state – older people were one, but others were also affected – who had moved out of the labor force and who became vulnerable to the charge of being a “burden” on society through social welfare (Powell, 2014). This partly explains the rise of ageism during the 1970s and 1980s, but more general tensions were illustrated in debates which presented older people as a “selfish welfare generation,” with the resulting possibility of “intergenerational conflict” or “workers” in potential conflict with “pensioners” (Phillipson, 1998).

The administration of the welfare state has undergone two major reforms since its inception. The first phase, covering the 1960s and 1970s, saw central government reformed in order to allow the planning and control of public expenditure by the Treasury. The aims of this reform were managerial efficiency and economic planning. The effect was to create a system in which the Treasury allocated resources to departments, and departments to services (Phillipson, 1998).

The second phase, which led in the 1980s and 1990s to restructuring of the civil service and the administration of welfare, was called the “new public management” (Powell, 2014). It has three main elements:

1. The breakup of the administration into agencies, so that the efficiency of each part of the administration can be assessed individually. Examples are NHS trusts and the administrative agencies responsible for Social Security.
2. The introduction of management with managers being responsible for running agencies in a business-like fashion; this is widespread in health and personal social services.
3. Quasi-markets. Public services are required to act more like economic markets, with the separation of purchasing and provision of services and the introduction of competition. The trend is strongest in health and social care (Cook et al., 2015).

From the 1980s a state emerged based upon minimal intervention and regulation via a rolling program of privatization, deregulation and contraction of services. For example, within the mixed economy of welfare, there has been the social construction of a market-oriented, consumer-based approach to the delivery of welfare and the role of older people as consumer pensioners. Yet, despite ambitious claims for the virtues of the market, the proportion of working-age people in the UK saving for their retirement actually declined over the period from 1999–2000 to 2005–2006 (Phillipson, 2013). This reflects the long-term fall in occupational pension provision, yet to be offset by the growth of personal pensions (Peston, 2008). Seventy percent of final salary schemes in the UK are now closed to new employees, compared with just 17 percent in 2001 (Phillipson, 2013). Robert Peston’s summary of the
pensions’ crisis bears all the hallmarks of the characteristics of “disorganized capitalism” in its post-industrial phase:

What has happened to corporate pensions funds reflects a change in the culture of the UK, the abandonment of the notion that companies have a moral obligation to promote the welfare of their employees after a lifetime of service. It is part and parcel of the death of paternalism and the rise of individualism. Company directors are no longer asking what it cost them to provide a comfortable retirement for staff. Instead, the majority of big companies are investigating the price of ridding themselves of any responsibility for their retired workforce. This is a less conspicuous but hugely important example of how the wealth of the many is being eroded, while that of the super-rich has soared. (Peston, 2008: 255)

As Powell (2014) claims, the state is being reorganized to include a retention of a strong center to formulate policy but the dissemination of responsibility for policy implementation to a wide range of private, public and informal modes.

More specifically, Alan Walker (1996) and Chris Phillipson (1998) in the UK have claimed that a “demographic threat” is being used as an ideological platform for a more general neoliberal attack on the welfare state in favor of both private insurance and greater personal responsibility for our own futures. What Walker calls the ideology of “familism” played an important role in the Thatcher government’s emphasis on personal responsibility for our families and their futures. As state support for welfare has been systematically eroded, there is a greater potential burden on family members to provide familial care, but in reality it is difficult for family members to undertake responsibility for older people because the notion of “family” itself has been changing dramatically. With high levels of divorce, increasing longevity and greater geographical mobility, families are often too fragmented and diverse to provide the care that occurred between children and parents in the traditional (extended) family. As life expectancy increases, families may often contain two generations of pensioners who need support.

Walker (1996: 35) concludes by noting that although “age-group conflicts have the potential for greater prominence in the decades to come,” whether or not such conflicts will be significant depends on how the state functions to enhance or undermine the capacity of individuals to provide care and support for family members.

Further, Thatcher’s policy of privatization of social and health care resulted in a shift of social responsibility for the “dependent elder persons” from the formal to informal sector of care. While the private sphere of the family has an important role to play, this should not be used to justify the passivity of the state in its public and formal role (Powell, 2014). Furthermore, the burden of care tends to fall unequally on female members of the family, thereby reinforcing gender inequalities.

Hence, the UK has a neoliberal system of government. The case of health care illustrates this. As Ham notes, there were essentially three components of the neoliberal approach when applied to health care (Ham, 1997: 8–9). First was that health systems required the forces of private markets to improve their efficiency and increase the range of services available. Driving this was a belief that central planners were incapable of producing ideas for health system improvement. The UK government had a preference for markets, public sector downsizing and privatization. The preference for markets saw the creation of a split between health care purchasers and providers, and introduction of contracting between these two parties, within previously integrated hierarchical health systems. Of course, in tandem with the purchaser-provider split, the UK reformed the organization of health care delivery. This included creating new corporate
structures to manage hospitals and requirements that publicly owned and/or funded agencies compete with one another (Ham, 1997).

Second, in keeping with “managerialism” was a desire to implement robust health care services management systems. This was propelled by perceptions that health care professionals lacked appropriate expertise in management, such as experience in running private business, and were incapable of making objective managerial decisions due to their allegiances with professional colleagues. Improved management also required an orientation towards “customers,” dedication to improved service performance through developing workforce objectives and incentives and devolving responsibility for these to appropriate units, and a focus on contracting out of services to induce competition and reduce costs (Powell, 2014).

Crucially, it required a concerted effort to improve performances in areas such as hospital average length of stay, waiting times for elective treatments, and health outcomes. To empower and provide incentives for improved hospital and other local service management, such responsibilities were decentralized (Ham, 1997). This meant that budgetary, human resource and service organization decisions were a managerial responsibility and largely separate from central government intervention – a tenet of neoliberalism that Margaret Thatcher arguably instigated against health care in the British welfare state.

Third was the reform of budgetary systems and creation of financial incentives to improve performance. A core idea, applied across government systems, was that funding ought to be oriented towards “outputs and outcomes” instead of simply based on prior expenditure and utilization patterns. Thus, policy makers required that providers develop information systems as well as methods for micro-managing workforce activities. This was so that funders (or purchasers) would be able to see exactly what they were paying for. They would also be able to see how these activities were contributing to desired policy outcomes (long-term health policy objectives) (Ham, 1997).

The mental health care system in the UK

The Conservative government installed in 1979 with Margaret Thatcher as prime minister vowed to address the political, social and economic problems the welfare state was alleged to have caused. In what Stuart Hall (1979) describes as “authoritarian populism” Thatcher was able to mobilize support for hardline policies through presenting the crises of Labour socialism. Thatcher’s propositions of what the faults of society were, and how to rectify them, were appealing to the anxieties of many. Attacks on immigrants and immigration, the synthesis of national economic problems and welfare costs, and the promise to tackle perceived excessive trade union power were all tantamount to an approach that attempted to structure a binary public imagination of “good” and “evil.”

The creation of deviant caricatures based on social circumstances and background rested on the demonstrating of an incongruence of values did little for any sympathetic view of the mentally ill, who had already existed on the fringes of society. Indeed, this view was provided with a further scaffold with the passing of the Mental Health Act 1983, which resisted opportunities to enhance the rights of patients, instead favoring the developing more sophistication in mechanisms for involuntary treatment and an expansion of control professionals.

Thatcher’s aim to reduce public expenditure saw several attacks on welfare provision as well as providing little opportunity to effectively finance health care initiatives due to the diversion of funding to other specialties such as primary care (Mechanic, 1995). Cuts to individual benefits and a transfer of controls over payments to local authorities (housing benefit) and employers (sick pay) began in the early 1980s. The means of growth was seen as a mission of duality: gain
control over inflation and enhance levels of individual responsibility. The promotion of schemes for home ownership cast those tenants in local authority accommodation as less virtuous, not least where the “peripheral problem council estate” was sold as generative of dependency on the state and criminogenic.

Despite unemployment reaching 3 million in Thatcher’s first term in office, and inflation remaining steady at 22 percent, policy remained staunchly focused on hard-line politics of contraction in public spending on welfare (e.g. child benefit frozen, Housing Act 1980 statutory “right to buy” for tenants of council properties) and statutory mental health services. The hollowing-out of the social security system could be seen further in Thatcher’s failed attempts to privatize the NHS and higher education during the 1980s. However, Thatcher’s second and third terms in office saw further revisions to welfare payments and eligible claimants, with means-tested benefits being normalized in addition to the abolition of free vision and dental checks (1989). Thatcher’s determination to quash the specter of dependence is captured in her 1987 remarks in a magazine interview in *Women’s Own*:

I think we have gone through a period when too many children and people have been given to understand “I have a problem, it is the Government’s job to cope with it!” or “I have a problem, I will go and get a grant to cope with it!” “I am homeless, the Government must house me!” and so they are casting their problems on society and who is society? There is no such thing! There are individual men and women, and there are families.

*(Thatcher, 1987: 10)*

The general pursuit of public spending reduction (and individual benefit reforms) meant that public services to support mental health care in the community suffered accordingly. As Boardman (2005) asserts, mental health services at this transitional point (between hospital and community) were drastically underfinanced and understaffed.

The beginning of the last decade of the 20th century began with the passing of the NHS and Community Care Act 1990. The implementation which took place over the next 3 years placed a legal duty on health authorities and local social services to devise needs-based care plans for psychiatric patients in the community (Thornicroft, 1994). The intention here was to combat inappropriate resourcing and to require tailored packages of support and care based on assessment to be applied to individual cases. This was a monumental step amid continuing constraints on resourcing and one which organizations such as the Mental Health Foundation (1994) were acutely aware of. Reviews of personal welfare benefits were also being undertaken at the same time. In 1992, the Disability Living Allowance (DLA) replaced Mobility Allowance in a bid to improve monetary conditions for those eligible in order to assist. As Burchard (1999: 6) explains, “the lowest rates became payable to those with fewer but nevertheless significant requirements, and the highest rates were made more generous than those of its forerunners.” An Incapacity Benefit was introduced in 1995, replacing Invalidity Benefit. However this reform carried stricter eligibility criteria and was also subject to taxation than its forerunner.

Social exclusion, trans-institutionalization (i.e. in the context of large numbers of remand and sentenced prisoners suffering mental illness and disorder – see Konrad, 2002), homelessness and poverty are just some of the circulating issues surrounding agendas of care in the British welfare system. The observance and wrangling of such issues largely remained in the domain of policy writers, academics and campaigners. However, challenges in the effectiveness of community care were brought into full public view through a number of instances of patient-perpetrated homicides. The 1990s forced politicians to confront issues of resourcing and the whole ideology of health care.
Concerns over health care arrangements were largely twofold. First, policy was too wel-
faristic at the cost of public safety (Burns and Priebe, 1999), and second, inadequate resourcing
precluded effective management. Public apologies by politicians were made amid pressures to
radically and immediately reform the community care agenda; however, the policy of commu-
nity care remained despite condemnation of mental health services. The passing of the Mental
Health (Patients in the Community) Act 1995 aimed to strengthen monitoring through Super-
vised Discharge Orders but at the same time acquired criticisms of anti-therapeutic responses
being deployed and an imbalance between therapeutic intervention and anti-therapeutic con-
trol (Eastman, 1995).

**Mental health and welfare policy: into the new millennium**

A change in government came in 1997, with New Labour winning the general election with
a landslide of 179 Parliamentary seats. In response to a continuation of concerns over the qual-
ity and breadth of mental health services in the community, the NHS Plan, launched in 2000,
proposed the commissioning of new national community services that would deal with mental
health crises, intervene earlier, and assertively manage illness and disorder in the community
context.

Actuarial discourses were a pronounced feature of much Labour government policy from
1997 onwards. This was not designated solely to mental health services, on the contrary; rather
the Labour government proposed policies that would reach into a variety of institutions and
contexts that aimed to govern problem behaviors before they happened. The management of
future "risky" behavior was the order of the day, with substantial revisions made to youth and
community projects and services and the criminal justice system broadly. Mental health services
and legislation also became increasingly built around controls informed by a predictive logic.

The New Labour government also set about influencing attitudinal reform to welfare ben-
efits. Principles of "workfare" rather than "welfare" reverberated through the Labour years of
1997 to 2010. The notion that welfare provision should facilitate a leap into the labor market
rather than an insurance against unemployment maintained its currency, with key political fig-
ures outlining that the best welfare for working age people is work itself (Social Security Secre-
tary Harriet Harman, May 6, 1997).

Skepticism and concern of such a tone can be found among the scholarship of authors such
as Bauman (2004), who argue that the presence of an undercurrent such as this is at odds with
the very concept of the welfare state as originally set out. Narratives of workfare were applied
universally and without discrimination in an attempt to instill a new social contract between
the individual and the state and to force a cultural shift from benefits and dependence to labor
and independence. Active systems of testing and review for claimants were installed in place of
what were considered as lackadaisical passive systems of claimant acceptance and subsequent
benefit payment.

The New Labour government's entry into power, and its developing values and beliefs on
welfare, posed several challenges for claimants enduring mental ill health. High numbers of
 Incapacity Benefit and Disability Living Allowance claimants did so because of mental illness.
This group, already stigmatized by virtue of psychiatric diagnostic labels and the misrepresenta-
tion of continued causal relationships of mental illness and dangerousness, faced increased public
and official attention for the welfare benefits being claimed. The mentally disordered individual
is therefore doubly deviant: first because of their medicalized identity, and second because of
their identity as a (potentially undeserving) welfare claimant. The second point may not have
been so relevant had the cultural shifts not taken place to illuminate and tackle the perceived
The UK welfare state system

burden of claimants standing in the way of increasing economic activity of society and abdicating responsibility.

Approaching welfare reforms in this way has the potential to designate lower socio-economic groups as welfare “scroungers” and undeserving. Tougher thresholds of acceptance onto welfare benefits and a shorter period of time in receipt of them may also be considered as a punitive measure against those who are the least well-off. Popular representations of the deserving and undeserving claimant have woven their way through tabloid imagery and political oratory and thus contemporary parlance on benefits, and who should claim can dominate readings of the situation through the creation of normative social scripts. The problem for the claimant that endures mental illness or disorder is twofold: first that a high number of people with mental illness experience poverty, and second how well accepted (in official and public observations) are psychiatric conditions as a legitimate claim.

Those individuals on low incomes or who suffer poverty are more likely to experience poor mental health (Stafford and Marmot, 2003; Fone and Dunstan, 2006). Moreover, the presence of mental illness or disorder creates barriers to gaining and sustaining employment, and thus makes those with mental illness more likely to enter unemployment that then affects their financial position. In such circumstances welfare payments are a primary source of financial support. Moreover, not all mental illnesses and disorders are viewed the same, and whether a condition is observed as a legitimate or illegitimate claim for benefits is subject to the nature and character of testing thresholds that change over time. The deserving and undeserving mentally ill are likely to be classified not on the basis of their presenting symptoms, but rather in a context that is heavily shaped by political imperatives concerned with welfare reforms (i.e. workfare) and fiscal policy.

Mental health and welfare: coalition responses

The coalition government (Conservative and Liberal Democrats) formed in the general election of 2010. Discourses of austerity prevailed, with a series of cuts in spending put forward, none more so than what was tantamount to a radical and fundamental change to the welfare state. Fiscal tightening on public spending and welfare support came in a variety of forms including the introduction of the “bedroom” tax, the Disability Living Allowance being replaced with a Personal Independence Credit, the introduction of Universal Credit and a welfare benefit cap.

Attempts to gain consent for policies of welfare contraction were done so through the discourse of austerity. Here, poverty and unemployment are argued to be the fault of previous governments’ creation of a culture of dependency; an over-generous welfare system that consequently ends with a rise in public debt. Such arguments are nothing new; indeed the Thatcher government proclaimed similar “truths,” however at this time a narrative of urgency and immediate action (virtuous necessity) was stronger due to the economic crisis.

In 2011–2012, the sick and disabled were the fourth-largest group (15.5%) of welfare expenditure after elder persons (42.3%), those on low incomes (20.8%) and families (18.4%) (Reid, 2013). Tacking the perceived excesses of dependency among welfare claimants and the creation of a discursive strategy is evident according to authors such as Wiggan (2012), continuing the language of welfare that New Labour had developed. Similarly cuts to public spending on mental health care had taken place over the coalition Parliament. In a study conducted by BBC News and the journal Community Care, amid referrals to community mental health services increasing by some 20 percent, NHS Mental Health Trusts in England have seen their budgets fall by more than 8 percent over the coalition’s term in office. Concerns over the impact
of rising referrals to mental health services and contraction of staffing and services undoubtedly impact on outcomes for people with mental illnesses and disorders (KF, 2015).

**Current and future issues for the welfare state system**

Current issues illustrate that the British welfare state has many different functions, such as the National Health Service (NHS), housing, disability, pensions and income support. The welfare state in contemporary Britain is bringing “together a number of agencies and institutions to deliver a sustainable social welfare programme” (Cook and Halsall, 2011: 21). Moreover, the welfare state is publicly funded, and recent political debates have focused on the investment in key services and on delivery.

The broad political consensus that has shaped welfare policy in Britain for most of the post-war period is now undergoing significant change. There is a shift from an inclusive welfare state to what has been termed a workfare state where benefits are being restricted and capped, as well as linked to the search for work.

According to the Institute for Innovation and Improvement (2015), the NHS is the fourth largest organization in the world, with 1.3 million people working for the service within a £100 billion budget. The NHS was launched on July 5, 1948, by Aneurin Bevan, the then Minister of Health. This institution has three core principles: (1) “that it meets the needs of everyone”; (2) “that it be free at the point of delivery”; and (3) “that it is based on clinical need, not ability to pay” (NHS, 2015). Throughout the 1980s to the present day there has been much political discourse on how the welfare state is run and how much it costs. Since the election of a Conservative government in 1979 which ran to 1997; a Labour government from 1997 to 2010; and the current coalition government, the debate has focused on privatization. Klein (1995: 154) has noted that privatization in the political arena has always caused a “longevity” argument and provokes “traditional reactions.” Both the Conservative party and the Labour party have privatized parts of the NHS in the past. The principle behind this is to improve the service. The future question here is if consecutive governments keep privatizing the NHS, will the service experience improvements?

There are a number of current issues that require key challenges to the welfare state in the UK:

1. There is the future relationship between restructuring welfare and health and social care resources: the relationship between social care and wider social and economic benefits with a scope to view the reform of adult social care not as an end in itself, but as a form of social and economic investment in local communities which can create new employment and business opportunities (Phillipson, 2013).

2. The British welfare state’s future relationship with the health service is central, including the need to develop a shared vision for community services, the need to make best use of scarce public resources and the need for more joint approaches to supporting people with very complex needs (Powell, 2014).

3. The relationship between the local and the national, with a constructive two-way dialogue needed between current debates about a more national settlement for adult health care on the one hand and the need for innovative local solutions on the other.

4. Overall, there are major future opportunities to refocus the adult health care system and to work much more creatively with social capital and community resources. However, the risk is that the severity of the challenges facing local government prevent the careful thinking, time and investment needed to produce genuine, long-term solutions for the welfare state (Phillipson, 2013).
Conclusions

With special reference to the mental health system, as we have seen, the linkages between poverty and mental health are well known. This poverty may be generational, and barriers to employment due to the presence of mental ill-health may exist for many. Indeed gaining and keeping employment for the mentally ill can be especially difficult due to stigmatization and myopic views of what exactly mental health conditions are and are not. Where barriers to employment are not overcome, a return to benefit claims may be required. This may be temporary or more permanent, however, if employability is contingent on “good” levels of mental health, then access to work is contingent on the quality and availability of services to support and treat conditions. As we have seen across governments, mental health services have been the recipient of discriminatory funding and an overall minimal resourcing. The lower status of mental health services against other medical specialties has hampered its development and growth, and this has therefore impacted on service users.

Political agendas have sought to increase labor market attachment and reduce welfare claimants. Labor market attachment therefore comes to represent social inclusion, and the benefit-claiming mentally ill, who are already socially excluded through their medicalized identities, are further excluded. Priorities of “workfare” rather than “welfare” rest then, in this case, on access to mental health services, and the risk of not fulfilling the “good neoliberal citizen” who is employed is ever too real. Those remaining as welfare claimants, and who cannot fulfill the aims of welfare-to-work strategies, succumb to greater hardship (which can exacerbate existing mental health conditions) where cuts to benefit payments take place.

The circumstances explained here point to those with mental health conditions being in receipt of (dwindling) welfare payments for a longer period of time than perhaps others who are able to engage in work programs. The popular use of imagery and rhetoric that cast the benefit claimant as “scroungers” and undeserving enhances stigmatization and reinforces social marginalization in the British welfare state. Such conditions leave the mentally ill vulnerable to a plurality of social exclusion. Not only are sufferers depicted as undeserving due to their lack of labor conformity, but this is set against the persistent stigmatization and prejudices that those with mental illness endure. Indisputably the creation of identities that are doubly deviant has a deleterious effect. At the same time many that do, or require access to, mental health services are dependent on welfare benefit payments. Their situation is precarious, as we have shown, and there appears to be little sign of the situation improving. The contemporary theme of austerity serves to legitimize a “hollowing-out” of welfare provision and public services in Great Britain.

References


