MANAGERIALISM, PSYCHIATRIC REFORM and the COMMUNITY

An overview

> *'Government…should be designed to work on behalf of a citizen community both to pursue its collective interests and to defend the citizen community against harmful effects of private market activities.'*
>
> *Anna Yeatman (1998)*

Introduction

Over recent years, the agenda of government has become clear – and it appears to be the exact opposite of the view expressed by Yeatman. This agenda, although made to look as if it is in the public interest, appears in reality to be based on an ideology derived from latter-day managerialist theory. The theory holds, as will be seen below, that managing economic issues is all that is required for the greater good of the community, as social benefits will follow and 'trickle down' to ameliorate such issues as inequity. Competition will have been enhanced, which in turn will drive efficiency, increased productivity, higher wages and lower unemployment. The theory further holds that this modern utopia will rid us of the 'evils' that befell us when we embraced a 'welfare' mentality – that really competing with each other is the way to increased 'personal responsibility', which we all 'need' in order to take advantage of the 'trickle down' effect of managerialist policy.

We will explore here, firstly, how a complex web of policy change is seemingly driving us further and further away from policies that embody a concern for the underprivileged (arguably one mark of a *truly civil* society) – and which instead is driving us into an exploitative, competitive frenzy, where more has to be done with less, and where helping marginalised groups is no longer the province of good governance.

Secondly, I contend that no matter how seemingly diverse the issues may be, they are all underpinned by the push to managerialise, to turn everything including social services into a business, and that the community can ill-afford the ethical dilemmas and social sequelae that will inevitably follow.

Thirdly, I will pursue the notion that managerialist theory has become the currency that drives policy – that policy is no longer based on the interests of the community, but rather is about furthering managerialism itself.

Lastly, the fourth point will argue that the implications for the entire community – in terms of increasing stress levels, decreased productivity, increasing alienation, social fragmentation and rising general medical costs – are grave.

Throughout this chapter we will draw on some of the key theorists in the managerialist debate, both proponents and opponents, to underscore the points raised above. Such theorists (Keating, Mintzberg, Yeatman and Considine), deal with current opinion on issues such as modes of governance, public management and group process. Some of their ideas will be explicitly held against examples of current practice, so as to provide evidence to counter the oft-repeated claims that we are caught up in fanciful apprehension (a view beloved of government in regard to any criticism!). I contend that we are dealing with very real dangers that need to be urgently addressed by the community.

The reader will note that many examples will deal with policy changes to the practice of psychiatry. These are emphasised simply because they are, arguably, the forerunner of problems that will beset the whole of medicine in the near future, with implications for the whole community. Issues from the wider field of medicine will also be introduced along with examples from current work practices, to highlight the pervasive and insidiously destructive nature of policy thrusts that inevitably lead to feelings of powerlessness rather than responsibility. Lastly, a case study will be used to show the human face of these changes, and the effects on ordinary citizens – so glaringly ommitted in current political discourse .

Psychiatry & the Ethos of Managerialism

Psychiatry is operating within a political framework which has become much more intrusive and demanding, with increasing emphasis on measurement of output and accountability. Dr Wooldridge, Federal Minister for Health, peremptorily announced budget cuts in 1996 to increase output and redirect resources to meet a perceived unmet need – a fallacious concept in itself according to Grant (1998: 256). That this was a gross intrusion on treatments in progress is an understatement which does no justice to the suffering caused by the legislation. In using the terms "output" and "accountability" here, we note their increasing use in everyday managerial discourse, as well as the confusion they gives rise to as they become unthinkingly equated with "efficiency" while at the same time undermining issues of "quality".

Quite why managerial discourse has risen to such prominence has been explored by investigating the increased relationship between a "scientific" paradigm and management (Yeatman 1987: 350). This exploration posits that, over the last two decades, public services have been increasingly managed by a well educated, scientifically oriented "elite", adding a level of technocracy to public service (and therefore governance) irrespective of political allegiances. The consequence for public service provision, and policy development, can be seen in remarks made by Yeatman (1987:339) when she observes "While the technical intelligentsia…..is open to rational debate and new ideas, *its members are not well equipped to take account of the substantive concerns of public policy and service provision"* (italics mine). It is this declining importance of *service* that lies at the heart of concerns over current policy.

It seems important then, to look at issues of governance and the push (which some argue is also a confusion) to make government more like business. This clearly influences policy directions that we all have to contend with – the move to turn medicine into a measurable and controlled commodity devoid of social equity issues and concern for the ill. An outstanding example of this exists in the current item 319 regulations - where Medicare rebates for long term psychiatric treatment were arbitrarily halved by a newly elected conservative Government, if they exceeded a pre-ordained limit. This effectively ended treatment for some, irrespective of the consequences . This was later only partially reversed despite strident criticism from consumers as well as providers.

The perceived need for increased accountability, outcome driven policies, and cost effective strategies can reasonably be said to emanate from an ethos of "managerialism" inherent in government initiatives. That the groundwork for this was laid down by the policies of a previous labour government suggests that such policies as managerialism and competition cross the political divides. Indeed, it has been argued that this has resulted from the changed social composition of the leadership and membership of the Labour party, which has resulted in a convergence of views in regard to the need for a technical, managerial mode of governance. This blurs the political divides while increasing the dominance of managerialism (Yeatman 1987).

However in addition, what concerns us here is whether implementation of the idea to "managerialise" public services such as health care , is in the interests of the community at large or whether it is being perverted by political decisions based on a philosophy of self-sufficiency - that Government has no place meddling in the personal lives of its citizenry. This is the "small government" argument that I maintain is promoting a "survival of the fittest (richest)" market-driven mentality devoid of social concern. The inevitable result will be that the divide between rich and poor grows ever larger, bringing envy and discontent in its train. As Woolhandler & Himmelstein remark (1999:446) *"The most serious problem with such care is that it embodies a new value system that severs the communal roots and samaritan traditions of hospitals, makes doctors and nurses the instruments of investors, and views patients as commodities."*

Theorists – the proponents of Managerialism

Proponents of managerialism acknowledge the sense of disquiet "about the alleged speed and extent of the changes (*to public administration)* and some uncertainty about what it means for all of us" (Keating 1989:123). Nevertheless Keating maintains that managerialism aims to preserve issues such as fairness and probity. So why the disquiet ? Could it be that it is far more than just issues of "speed and extent" of change, far more than this assertion that we're all just having trouble keeping up with change (surely a value judgement in its own right).? Might it not stem from his claim that "Australia is living in a competitive world where major structural adjustments are being asked of the rest of the community" (1989:123) and that these structural changes are really *not* ensuring fairness and equity ?

It should be noted that in this paper Keating addressed to issues of management which beset financial departments in government – but this is arguably paralleled in other government departments. In summarising the characterstic of the required reforms to administration, Keating refers to "*management for results*". He places the focus on the "cost effective achievement of outcomes rather than *simply* on inputs and processes" (italics mine). One can again note the seeming prioritizing of "outcomes" in which it seems that everything can be reduced to commodity status; measured and controlled but with no guarantee of quality and without apparent interest in *social consequence*. However Keating rejects this, arguing that the attainment of social justice has been enhanced by better management methods (1989:129). This raises the possibility that it is a too rigid adherence in implementing program mamagement methods that defeats any real gains in areas of inequity. Keating then outlines the fundamental principles on which managerialist reforms rest. These are in essence, based on the principle of the devolution of responsibility, through the removal of constraints on managers, increasing their authority and (therefore) their accountability whilst scrutinizing their "outcomes". This is to be accompanied by increased review and evaluation which, it is claimed, will lead to enhanced program management.

In reality though, anecdotal reports from those working in such systems show that lip-service only is paid to the scrutiny of managers, that managers are in an ethical conflict of interest (vis-à-vis their employees) if their own job depends on "outcomes". Therefore what is unwittingly recreated is a feudal system which potentially promotes the abuse of power. Clearly, the implications are not positive from an emotional point of view for the vast number of employees – and this is of increasing concern given World Health Organisation predictions of approaching rises in mental illness (Brundtland 1999) within the next decade: "*Worldwide, mental disorders accounted for approximately 12% of all disability adjusted life years lost in 1998. Their contribution is higher in high-income countries (23%) ……all predictions are that the future will bring an exponential increase in mental problems. "* Interestingly, Keating himself notes (1990:395) that *"It is arguable, however, that the public service should adopt a higher standard of ethical conduct* (and one might assume in policy formulation also ?) *because of the significance of many government decisions…"*

In noting the "new language of public administration", other proponents of managerialism (Paterson 1988:288) make no apology for difficulties that might thereby be created. For instance, terms such as 'performance measurement', 'corporate planning', 'program evaluation', 'devolution', 'executive service' are cited as examples of the language of these reform endeavours. Critics such as Considine, however, point to implied problems in the use of this language (in Paterson 1988: 292) – viz: that it derives from a "technical" rationality that does not necessarily embrace notions rooted in ethical or values-based rationalities. His argument is that competing frames of reference may push each other out thereby precluding a holistic understanding of community issues, and reducing opportunity for debate.

Nowhere was this more evident than in the difficulty faced by negotiators for psychiatry in trying to find common ground with government when attempting to reverse the 1996

Budget funding cuts to Medicare rebates – the frames of reference could not 'overlap' as one focused on 'outcome' while the other focused on 'process'. Further, a perverse use of language that promotes secrecy is helping shape these managerial agendas. For example, we see an increasing call in medicine for clinical decisions to be 'evidence-based', a notion arising from a movement known as 'Evidence-based medicine'. The latter in turn is originally derived from a project known as the Cochrane Collaboration based in the United Kingdom. As a founding ideal this project sought the collation of medical knowledge to assist its dissemination and thereby reduce unnecessary duplication of research effort and resources. However, Dr Cochrane himself was quite clear in his *opposition* to the possibility that the Collaboration might be used to *reduce* treatment options if these options were clinically useful but no evidence for their efficacy could be found (eg if the particular treatment option didn't easily lend itself to measurement but was nevertheless useful). However, politicians have increasingly invoked the concept of 'evidence-based medicine', while pointedly ommitting the exclusions Cochrane himself emphasised. It is now used to imply that lack of evidence equals lack of efficacy; thus rationalising reductions in funding for treatment. Language itself becomes a tool for dissemination of misinformation, promulgating a managerialist, economically-driven agenda, through ommitting highly relevant pieces of information. As Woolhandler & Himmelstein (1999) point out in a recent editorial on related issues :
' *Efforts to evaluate care are no match for profit-driven schemes to misrepresent it'.*

Theorists – other opponents
In opposing market-driven "reforms" Yeatman (1998: 138) argues that the erosion of the role of government in monitoring social justice issues (due to a *laissez faire* mentality) has allowed a situation to arise whereby transnational corporations believe that government should respond to *their* agendas, at the *expense* of the citizenry. One might argue that this is reflected in the stance of the Private Health Insurance Association under Mr R Schneider who openly advocates for the introduction of managed care strategies into Australia. Nevertheless, Yeatman (1998: 138) also refers to the crisis in public sector administration as providing opportunity for the 'reformulation of citizenship values and ideals so that they are responsive to new standards of inclusion and justice', perhaps indicating an increasing awareness of, and disenchantment with, the social sequelae of managerialism.

Professor H. Mintzberg, well known for his theories on governance, remarks that we tend to think of ourselves as living in capitalist societies that have outlived their communist counterparts and are therefore, thought of as 'better'. However, he claims that it is a fallacy that capitalism 'triumphed' – rather he feels that "*balance*" triumphed. For example, he considers that we have 'been living in balanced societies with strong private sectors, strong public sectors and great strength in the sectors in between'. Further, he states 'the belief that capitalism has triumphed is now throwing societies *out* of balance…..that the balance will favour private rather than state ownership will not help society'. The latter point is ignored as governments push to deregulate and privatise, making government more like business.

Business, however, is about managers "maintaining an arm's length relationship, controlled by the forces of supply and demand". One could argue that this is behind the government's keenness to have insurers enter health decision-making processes – ie not out of concern for quality or availability, but in the end to put government at "arm's length" from the public in any problems that subsequently arise from adopting a business model for medicine.

Management is underpinned by three assumptions viz: (1) activities can be isolated into units with clear goals (2) goals can be quantified and thus measured, leading to the illusion of "objectivity" (the Relative Value Study comes to mind here) and (3) activities can be entrusted to managers (Mintzberg 1996: 78). But, as the author points out, many government activities must interconnect, and few of the real benefits lend themselves to measurement – 'many activities are in the public sector precisely because of measurement problems' . Space does not permit a thorough description of Mintzberg's views of different styles of governance, but suffice it to say that the current Governmental style is, according to Mintzberg, likened to a 'Government-machine' model or worse, a 'Performance-control' model – whose characteristics are suggested in the labels! But as an alternative, Mintzberg describes the 'Normative-control' model of governance which he claims is not about 'systems' but is about 'soul' – where *attitudes* count more than numbers, where control is rooted in *values* and beliefs, where guidance is achieved by *principles* rather than imposed plans, and where leaders practise a management style which is grounded in experience. This then necessarily embraces the concept of '*service'* with a key feature being *'dedication'*

> *'An organisation without human commitment is like a person without a soul….this conclusion applies especially to client-oriented professional services such as health care..which can never be better than the people who deliver them'* *(Mintzberg 1996)*

Ethics & Managerialism

Increasingly, we are witnessing the emergence of articles which concern themselves with the ethical implications of competition policy – the latter being a direct product of the performance- control style of managerialism. Komaseroff, for example states : "opening up medicine to commercial interests and the promotion of economic competition has undermined fundamental values and seriously threatens health care". He describes how medicine (and psychiatry arguably more so) is about providing meanings and value, which relies on openness and trust *in a relationship*, and that this kind of contact is the "irreducible core of clinical medicine".

This view (from someone who stands outside of medicine, ie an ethicist) stands in stark contrast to those expressed in eg the MacKay Report (a semi governmental consultancy on workforce issues in Psychiatry) which state that we should "probably operate more as consultants" ? This idea derives from a dubious economic imperative, and does not take into consideration that our primary relationship *cannot be* with others who do the actual

treatment, we cannot become "arm's length psychiatrists". That is to say, the "arm's length psychiatrist" model would lead us into a decline in the connectedness with one's patients, would lead us away from a personal responsibility so that in the end we become alienated from our "core business" – we become managers rather than clinicians and therefore become prey to the ethical conflicts of interest outlined above.

Moreover, the idea of us acting as consultants will lead very easily into the kind of mediocrity that Mintzberg describes in his damning critique of certain aspects of strategic planning – viz: it will promote "stability in the name of change, reification in the name of flexibility, detachment in the name of commitment". The latter notion of "detachment" can be seen in a curious but worrying suggestion contained in another semi-governmental report, the Tolkien Report. It went as far as to suggest that we might only treat patients if they met standardised, predetermined criteria for illness *that would be determined by questionnaire – ie one had to fill out a form prior to being thought of as genuinely ill !*

We anticipate therefore, an emphasis on output ("value for money"), and measurement of performance so that "underperformance" (along with attention to detail and error avoidance – Painter 1998) is punished in order to bring about greater efficiencies and cost-effectiveness ("obtaining the best outcome for consumers" by embracing restrictions under the guise of "integration") – while not providing *actual* care. Management will be devolved along with responsibility, so as to encourage "innovation". Funding restrictions are used to achieve these managerially-inspired ends.

All of the above is predictable, according to critics of current public management theory. One such critic, Painter (1998 p3), remarks that "if….the quality of public services will decline as a result of the application of these ideas and practices, then their advocates will need to have the case for the defence better prepared". Have events not borne this out, for example in the increasing complaints about long public hospital waiting lists to see surgeons as well as psychiatrists, leaving ill people to fend as best they can ? Yet we embrace such policies so that this decline can affect the private sector also – as care is increasingly managed by adopting the "efficiencies" of a decimated public sector.

Integration – a managerialist concept

In a thorough critique of current management reforms, Considine discusses the central issue of "integration" – a concept familiar to psychiatrists from the "Coordinated Care Trials" and the "Integrated Mental Health Services Project" currently being trialled by the government.

The Integrated Mental Health Services Project (IMHSP), was designed to coordinate the care of individuals whose needs crossed various medical disciplines, in an attempt to achieve cost reductions. However, it became clear that what was purported to be a trial to reduce costs was perhaps in reality a way of radically altering the way medicine is practised, and entailing hidden consequences for patients in need of care. For example, the Project promoted patient management by "a team" thereby relinquishing any rights to confidentiality (a particularly sensitive issue in Psychiatry). They would also give up the right to claim benefits from Medicare, the national insurer. This was due to the fact that

the Project was / is based on a "pooled funding" model, from which *all* expenses were to be taken. In addition, the pooled fund would be administered by *a manager*, or a third party. There was no provision, in the IMHSP, for any eventuality that might require additional funds if the pooled amount were exhausted.

The introduction of this purchaser-provider split and administration by management would, at one stroke then, have set a dangerous precedent for the rest of medicine, leading to reductions in the "pooled" amount over time and therefore cost reductions at the expense of quality care (ie rationed treatment).

Readers might be interested to know that the IMHSP was withdrawn after much protest from providers and patient groups alike. It has since *resurfaced* in almost exactly the same form (and with the same problems) but is now known as the National Demonstration Projects in Integrated Mental Health Services – again showing an alarmingly cynical disregard for the concerns expressed. This is yet another instance where language is used to obscure the real agenda (in this instance by changing the name but leaving the substance intact).

Considine (1988 p14) argues that in effect integration produces an "elimination of divergent and contradictory action". This is the very thing, he goes on to say, that mitigates *against innovation* in any field : "we know from other research that overlap, multiple sources of advice and split responsibility are often a rich source of innovation and consistency in organisations". Or as Behn contends (in arguing against strict adherence to a formal strategic planning model) "the name of the successful game is rich, informal communication" (p650), raising the issue (for example) that the purported aims of the IMHSP might have been achieved more easily by simply facilitating payment for non-contact work/communication between General Practitioners and Specialists – the former being in the best position to "coordinate care" without managerial interference.

Another related but worrying trend is what Mintzberg refers to as the "fallacy of detachment" inherent in ideas of strategic planning; this describes how it is a fallacy to believe that managers who are divorced ("detached") from the coal face can be *more* effective as visionaries. The need for strategic planning in organisations is currently accepted as an orthodoxy aimed at integrating diverse functions, but Management becomes a task (an end) in itself. What goes unnoticed is that managers who take such a formalised view of strategic planning "become disconnected" (ie., from the core business *as it is practised*) as they increasingly rely on "measurable hard data" and "trends". They lose touch with the workers, or as Mintzberg (1994) claims "these planners necessarily become detached from the strategy making process or, *in those organisations that believe strategies can be planned formally, the process becomes detached from reality".*

These then, are the difficulties inherent in current directions of government policy, in which it can be fairly argued there is a discernable push (starting with psychiatry, and cynically based on the assumption that emotionally ill patients might not protest) to "soften up" the public , to get the community used to having to do with less. This is

achieved by using the politics of punitiveness and blame – for example, by attacking the "rorters", (as psychoanalysts were referred to in Federal Parliament), in the system as justification for wholesale cuts that demonstrably affect many more people than just the "rorters" (Hansard, Sept. 1996). Citizens are enjoined to be self-sufficient while the usual safety nets for the underprivileged that mark a civilised society are largely abandoned. Witness for example the closure of mental health facilities in various states without a corresponding increase in funding for *actual* community care. Funds are provided for promotional "awareness" campaigns instead.

These effective funding cuts have led to Coronial enquiries (in South Australia) into the alarming rise in suicide rates in the patient population and to union strike actions (again in South Australia) by both Nurses and Doctors at the closure of still more public hospital beds (this after the death of a patient while waiting for treatment in a casualty department due to lack of available beds). Similar problems beset other state-run public hospital services.

On a broader scale, policies are enacted that make it harder for ordinary citizens to achieve equitable wages (employment contracts) and these cannot be fought (for fear of retribution) nor compared and contrasted with other employees conditions (commercial-in-confidence clauses prevent this). People are asked to do more but are rewarded less – there is no tenure, and an increasing climate of job insecurity. The effects of this on the health of the community at large cannot, and should not, be underestimated.

A Case Study

Lest the above be seen as a mere abstraction, a (not uncommon) case example makes the point. Mr G is in his late 40's and works in a tertiary educational institution. He sought long term psychiatric treatment some years ago for recurring and debilitating episodes of suicidal depression with panic attacks. These episodes were so severe that he rarely held a job longer than 12 months despite his qualifications. Previous biological treatments had failed. The root causes of the emotional disturbances seemed clear enough – a mother who was chronically depressed herself and unable to care for the child in any consistent way, a father whose job made him largely absent but who, when present, was declining from alcoholism. Violence and repression were the prevailing forces in the family. To add to this, Mr G's family moved almost yearly, making enduring relationships outside the home impossible, and his mother became psychotically depressed for many months during his middle childhood years.

Clearly, to work through the many traumatic experiences that beset this patient would take a long time – but it was his last chance, as Mr G put it. His future (literally) depended on it, as did the future of his family and his only child. The child, by this time, could not help but be affected by the father's moods and developed problems of her own.

In essence then, although there was only one patient in the consulting room, there were two other people who were critically affected by this treatment. Mr G has, it is pleasing to note, made substantial progress in his treatment to date as his insight has grown – insight

into how he has unwittingly recreated long-forgotten traumas, and into how he can now change those recreations that seemed to be so alarmingly threatening from day to day. Mr G's therapy offered increasing hope and the prospect of reward for hard work on various fronts, emotional as well as in the work place.

Imagine then, Mr G's reaction when (having risen to manage a small but increasingly valuable Department for 3 years) he is "sacked" – but reinstated on a contract due to the managerial reforms sweeping through the institution, - reforms that meant there was suddenly no guarantee of income / resources for his family and leaving them potentially destitute should the contract be terminated. Imagine his reaction when soon after, the Health Minister announces changes (item 319) that threaten to severely curtail his treatment unless he meets a set of arbitrary criteria *or can pay from his already diminished resource* – or when he learns that, in the Fedreral Minister's view, he may not qualify as "really in need". Imagine his reaction when he is obliged to accept unqualified staff at work – because protest on his part led to his being told that his resignation would be willingly accepted (this from autonomous managers who in effect are accountable to no higher authority than themselves, and are focussed on "outcomes").

Mr G's workplace has rapidly changed from a place where the core business of educating made it an innovative and vibrant place that attracted talented staff – to a place where adhering to manuals and filling in process documents and reviews for funding are now the core business. People are required to work harder with decreasing resources, and with no prospect of finding alternative work should they decide to leave – they're trapped.

As one can see, some aspects of the changes directly parallel Mr G's original family environment. The abuse of power by the manager / father who threatens a violent expulsion if there is no submission, is an example; as is the increasingly depressed mother / workplace atmosphere with its deadening effect on creativity ,interdependence and the fostering of mature relations. Another is the perilous financial state he and his family are now in due to the contract – a position that mirrors the lack of reliable resources from ill parents in the original family. Mr G regularly reports the views of an increasing number of his peers – that the sheer illogicality of the changes (home) makes it seem "crazy" .

It is difficult to capture, in words, the sense of despair and disillusionment felt by this man that after so many years spent on hard emotional development, it all appeared to have been to no avail. He felt, correctly, that the world had recreated the environment he'd fought to overcome. It is equally difficult to not share his view, that managerialism is being promulgated so uncritically and unthinkingly that it borders on being actually "mad", the sign of a society seemingly out of control, with no time for reflection or principles.

It was noted above that Mr G's case is not unusual. It is not unusual in the sense that his is the kind of issue psychiatrists deal with increasingly in their day to day practice. It is not unusual also in the sense that these issues beset increasing numbers of people, whether they become patients or not. To stereotype people with these severe kinds of

problems, (as bureaucrats and politicians are wont to do to justify funding cuts) by labelling them as bored housewives living in the eastern (affluent) suburbs of cities (Hansard) betrays the contempt for ordinary citizens which has insidiously crept into the debate, and further betrays an alarming lack of *real* knowledge about the issues facing a desperate community.

Discussion

As mentioned earlier, the World Health Organisation tells us that depression and stress are to be the major epidemiological issues that will confront the western world in the next millenium. One can understand why, given the not unusual example above – Mr G is not the only one in this predicament.

Mr G's case is instructive in different ways. It has already been noted that his treatment (which by a kind of "ripple" effect has also helped his wife and daughter) was potentially severely affected by the introduction of the item 319 legislation. The arbitrary capping of this kind of treatment is not only grossly discriminatory, but betrays the lack of concern for the ordinary citizen inherent in government policy.

Further, all patients with similar severe problems are actively denigrated by the continued existence of this legislation, requiring as it does a disclosure of one's private problems (by way of diagnosis) to claim Medicare rebates. That the Federal Health Minister has repeatedly referred to therapists who provide this kind of intensive treatment as "rorters" is clearly derogatory, not just of the profession but also of patients who desperately need assistance in life threatening circumstances which usually go unnoticed.

We know that treating these kinds of problems saves the community from vast unnecessary expenditure, as demonstrated by international research which clearly shows the cost reductions in general medical expenses when psychiatric treatment is freely available (Gabbard 1997). Further, more recent studies have demonstrated that the community *actually pays more, not less,* when hospital services are privatised and become "for – profit" organisations in the managerial mould (Silverman et al). Yet, managerialism rules and treatment options are cut, profits and not people are held in the highest regard, and all the while Government talks about the need for "social coalitions" with business. Arguably this is really intended to make business the "fall guy" for Governmental negligence of the people it is there to serve. In addition, the clear avoidance of available evidence betrays the truth – that the aims of managerialism are the paramount issue to the exclusion of everything else. This is despite reversals of such policies in the United Kingdom, for example, where they have been shown to be utter failures in the area of mental health services.

Conclusion

The many and seemingly complex changes outlined above are unfortunately repeatedly defended by politicians and their bureaucrats ; their rhetoric is aimed principally at an uninformed audience (the public) and designed to make their regressive social agenda

look *plausible, necessary and in the public interest*. For example, we are often told how our ageing population will drain our scarce medical resources, how rationing is therefore the *necessary but tough* decision required in the greater public interest. What we are *no*t told, however, is that an internationally respected group of world health economists all see this as *nonsense* (ABC Lateline 6/7/99). They argue that if that were the case, the whole of Europe (which has a higher proportion of aged citizens) would already have foundered. Further, some argue that the very debate on how to ration medical resources is misguided – that instead the Government ought to be developing policy based on *what kind* of medical system is required, not *how much can it be downgraded !* There is little sense in reducing available treatment options on the basis of a scarcity of resources, while those same options have been demonstrated to *save* resources.

These problems *are* cause for disquiet, to paraphrase Keating , but require all citizens to rethink their role in allowing such Governmental policy to exist and flourish. We are in danger of allowing, by passive acceptance, the promulgation of a social agenda based on a cynical exploitation of others – but it'll be called "competition policy". We are in danger of being duped by the culture of secrecy sweeping through government agencies, that will not allow a complete and free flow of transparent information – in order that opposition and criticism will be quashed. The end result can only be a worsening of the divide between the "haves and have-nots", and social instability will prevail. We will all be reduced to debating banalities, because the real agenda will be happening somewhere else, behind closed doors. Ethical decision-making, social concerns, equity and inclusivity in policy formulation will have all fallen by the wayside – to be replaced by cynicism, alienation and pervasive feelings of powerlessness the more distanced we become from the political process.

It is only by remaining consistently aware of the insidious hold that managerialism has assumed over current political discourse , and demanding that governments *not* abandon their social responsibilities can this be turned back. That demands that each of us take our future into our own hands – by becoming more vocal and active to achieve these aims. This in turn, can only be achieved if we defend our right to have our own opinions about what constitutes good government, *and to express them* . We should not take too literally the simplistic notions of self-sufficiency espoused by Government, because this actually equates complaint & protest with a lack of self-sufficiency and thereby induces powerlessness through guilt. The agenda of governmental managerialism is clear – devolve responsibility for everything, especially issues of social justice and equity, onto someone else - anyone else ! This will leave us all floundering for a sense of community - and only public awareness, opinion and action can turn this managerialist tide.

> "*The challenge to the individual at all levels of responsibility is the ability to retain individual judgement within the surround of the group… the test is to have one's own opinion in the midst of group thought ."*
>
> *Leo Rangell*

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