How recent politics may reshape psychiatry in the UK; should we fear the market if Capital has love in its bosom?*

Martin Blanchard

*Through the incorporation of living labour capacity into the objective components of Capital, the latter becomes a monster endowed with life, and begins to function 'as though it had love in its bosom'.[1]

The aim of this essay is not to expose any conspiracy but to examine the natural action of change in a system and its interaction with human needs, wants and behaviours. It relies heavily on works of Karl Marx from 1845-1893, and David Harvey, who, alongside many other projects, has spent most of his working life reading and teaching one book-Capital. It does not conclude whether these changes in the system are for the better or worse; but it tries to describe the probable consequences of a perfectly working capitalist free-market economy controlling a public service, and relates this to actual observed change and practice.

Why do we need the market?

The usual reason given for markets is the need, in essence, to increase production and improve cost-effectiveness; to have better products and services for lower costs. Along with an austerity agenda, which the UK has been pursuing since 2008, an expansion in the place of the market is intended to increase employment and reduce the need for societal costs that do not obviously generate financial wealth, such as welfare benefits, and housing aid. The use of the free-market, as conceived by the current neo-liberal form of capitalist ideology, is seen as the most productive way to stimulate business and investment so that the National Debt can be reduced and we, as a nation, can succeed in the global market. Since the 2008 banking crisis, sweeping changes have occurred in the Health Service, but with hindsight it is clear that the groundwork required for change started as far back as the economic crisis of the seventies, and has proceeded gradually since then, using Kaiser Permanente (a private medical provider in California) as a touchstone, with the development of a purchaser/provider split, the internal market and Foundation Trusts. A 'good business environment' continues to be developed within the NHS, encouraging businesses to gain profit, and as part of this, the practice of psychiatry, arguably the least scientific branch of medicine, will undergo the changes required of any developing business under our current economic paradigm. But what are these changes and what may they mean?

What was the NHS?

Since its post war inception, the NHS as a 'gift' to working people has been able to function in the way that it does because it has primarily been funded through the

[1] Marx K. Capital Volume 1 (1867) Penguin Classics 1990. p 302 quoting Goethe's *Faust* Part 1 Auerbach's Cellar in Leipzig, line 2141 ('als hätt es Lieb' im Leibe').

general taxation system, in a similar fashion to the funding model for fire and police departments. With the absence of a competitive market it could be seen as a 'natural' economy[2], where in the main the 'value' of any action is determined by its 'use or utility' (individual or population, clinical) and, where 'exchange relations' –i.e. when products are taken to the marketplace and 'valued' in relation to other products - have not developed (see below). Financial monitoring and controls have been absolutely necessary to limit an ever growing budget related to new and expensive technologies and greater needs and expectations from a growing and more informed population. Efforts to date have been focused on financial decisions about the needs of clinical populations and on cost benefits. The introduction of Capital to this 'natural' economy brings apparent cost efficiencies and standardization, and for this alleged purpose capitalist economies have developed throughout the state-funded sector. But they also bring new needs, those of investors, and with them the difficulties associated with the process of wealth extraction from public services. Capitalism's influence has waxed and waned to a degree since its beginnings three centuries or so ago, but the effects of recurrent economic crises and the dominance of the use of liberal and subsequent neoliberal ideas to try to 'solve' these crises have served to heighten the effects of the social and economic change it produces.

What is ideology?

In society we never encounter the world directly, but rather through prevalent conceptions and beliefs, and these beliefs act on our relationships with the real world and people. The beliefs function as 'lenses' through which we see the world, and it is what we see that affects how we think things happen. An example would be the belief that luck plays a key role in how the world works, with the outcome of things determined by some external agency. This particular 'ideological relation' leads to the belief that things are beyond our control, with the future lying in the hands of providence, or some other powerful agency. 'Reality is distorted because our ideas and beliefs grow out of our social relations. It is these material relations that act as distorting lenses through which we come to perceive the world and our relation to it'[3]. In order to gain an insight into the enormous power such relations may bring to bear Marx gives the example in his Grundrisse[4] of how slavery should be considered the product of social relations rather than an accident of nature. 'Society is not merely an aggregate of individuals but rather is the sum of the relations in which these individuals stand to one another. Outside of society a slave is but a human being; whereas inside society a slave is the result of a socially determined relation, and thus only a slave in and through society'.

[2] Marx K. Capital Volume 2 (1893) Progress Publishers 1956. Trans. I. Lasker p133

[3] Marx K. with Engels F. The German Ideology. (1845) Prometheus Books 1998.

[4] Marx K. The Grundrisse (1857-61) Penguin Books NLR 1973 p 20.trans. Martin Nicolaus

Our society's current major laisser faire or 'minimal state' ideology[5] can be glimpsed by examining popularly held views on why people are rich or poor. The rich are seen as industrious, well-disciplined and frugal, while the poor are lazy, spendthrift and undisciplined-and therefore less deserving. Importantly, all these traits are the responsibility of individuals, and therefore it is claimed that success or failure is down to each of us. As far as state help for individuals is concerned this can be summed up by Ronald Reagan's comment that 'Government exists to protect us from each other. Where government has gone beyond its limits is in deciding to protect us from ourselves'[6]. The only justified actions of the government become provision of law and order including the protection of property rights, National Defence and the supply of infrastructure. Only services that are absolutely necessary for a functioning market economy to exist are necessary; anything beyond this, whether it is minimum wage legislation, the welfare state, tariff protection or state provided health care is seen as violating the sovereignty of the individual[7].

There is a striking similarity between the laisser faire ideology and some recent American libertarian ideas in mental health. Both claim an antipathy to any generalised sympathy for people in trouble, and advocate an indifference towards the sick and needy. In place of sympathy, laisser faire 19th century philosophers such as Herbert Spencer, who moved from Britain to the USA, calculated the long term risks involved to society by supporting the 'inferior', and the economic value of supporting the sick[8], while the psychiatrist and psychoanalyst Thomas Szasz points out the increasingly popular idea (in mental health and social care) that the 'ethic of helpfulness' is actually very bad for the person being helped, since such altruistic notions 'conspire as it were to foster man's infantilism and dependence'[9]. In a damning critique of aspects of the anti-psychiatry movement in his book Psycho-politics, Peter Sedgwick[10] states that 'the laisser faire purists of today find it difficult to announce that the inferior are to die, because the inferior themselves may overhear them saying it'. Of course in reality the poverty of the great majority of people in this world is a tale of oppression, expropriation and robbery, and mental illness is strongly associated with poverty, debt, unemployment and homelessness.

[5] Chang H-J. Economics: the user's guide. Penguin 2014. p 380

[6] Ibid.

[7] Ibid p.381

[8] Spencer H. The Man versus the State: the new toryism; the coming slavery; the sins of legislators; and the great political superstition. Reprinted from The Contemporary Review 1884 by Williams and Norgate 1902

[9] Szasz T. The Myth of Mental Illness. New York 1961 p 303

[10] Sedgwick P. Psychopolitics (1982) Pluto Press Ltd. p 64

What then is capitalism?

Using a textbook definition, capitalism can be considered to be the forcible separation of the means of production from workers[11] (in healthcare for example this would be professionals required to have primary allegiances to a private employer working in privately owned hospitals, clinics, and surgeries), resulting in the possession of a monopoly over the means of production by a part of society to create (or bolster) an economic hegemony. With the growth of capitalism there is a natural emergence of exchange which reshapes all social relationships, with economic exchange replacing or modifying what was (or could be) social (and/or clinical) interchanges. Alongside this there is a continuous 'accumulation by dispossession'[12] or coercion by private individuals and companies, using the power of a complicit state, to transform any state owned possessions into privately or jointly owned. Workers (health care workers as citizens) and the state (citizens) then lose ownership and control of what was theirs through democratic agencies.

It must be stressed that capitalism is not simply the name for a type of economy but is a definition of a network of social relationships formed between individuals. To comprehend how capitalism may affect us beyond the superficiality of neoclassical economics 'supply and demand', it is necessary to examine some of its principles in greater depth, elements that otherwise remain hidden behind the major ideology.

Labour and types of value

Use-value

Useful labour is the capacity of any human work to bring about usefulness or utility and create what could be seen as simple 'use-values'. This could be by creating an actual product e.g. medication, or providing a service e.g. dressing a wound. Every use-value will be qualitatively different from another and the product of different kinds of labour. Labour in its useful form has been going on for thousands of years and is independent of society. However, in a capitalist society the products of labour are subject to buying and selling in a vast system of exchange where they are presented to market as 'commodities'. In order for markets to work however, commodities need to be commensurable in exchange so that they can be traded by quantity, but how can they be when each commodity serves a unique function, has a specific use-value and satisfies a particular human need?

[11] Oxford English Dictionary online accessed May 2020

[12] Harvey D. The Enigma of Capital (2010) Profile Books Ltd

Value and exchange value

The answer is to look beyond the heterogenous material qualities and quantities of the commodity itself and invoke a concept called ‘value’. In capitalism alongside the cost of raw materials, value is a measure of the amount and type of labour that is required to create the commodity in a particular society at a particular time (Marx calls this ‘socially necessary labour time’). Then, only by taking the commodity to market will the capitalist know their commodity’s true worth in comparison with all other commodities in the market (globally this will be millions of others). This is the commodity’s ‘exchange-value’. It is easy to see how changes in fashion, new technology, advertising, changes in social beliefs etc. could all affect ‘marketability’ and so exchange-value. If your commodity does not sell then what value is all the labour and materials put into it? This means that ‘exchange-value’ as such exists outside use, and does not lie in any commodity as a substance, but is rather a product of a social framework[13].

Exchange-value is fundamental to understanding capitalist social relationships; in a marketised system with millions of commodities, exchange-value becomes predominant to an unprecedented degree and shapes all other social relationships. However, perhaps even more important than this is to realise that the true product of the capitalist production process is neither a mere commodity with a use-value nor is it a commodity with an exchange-value. The specific product of this process is rather ‘surplus-value’ or profit. The product is therefore commodities which possess greater ‘exchange-values’ than the labour and the material purchased to produce them. The ‘labour process’ appears in the capitalist production process merely as a means, while the ‘valorisation process’, or the ‘production of surplus-value’, appears as the goal.

The importance of Money

The sheer size of capitalist markets creates the need for a special form of commodity that is able to physically represent value, and as such it is money that permits ‘value’ to start to ‘crystallise out’ as the guiding principle of capitalism. We are all aware that money is much more than just its physical (or now electronic) form. It carries with it a ‘phantom’ form, of the social relations behind commodities (i.e. all the work, effort, travel, social constructs and beliefs etc. that go in to whatever it is used to purchase). Thus using money helps us to understand what ‘value’ itself is, it is immaterial (in the philosophical sense) but objective; although it appears to be common sense to assume that value can actually be measured, in reality it cannot. You cannot measure it directly - indeed as Harvey states ‘to find value in a commodity by just

[13] Rubin I. Essays on Marx’s Theory of Value (1973) Montreal: Black Rose p 63-75.

looking at a commodity is like trying to find gravity in a stone'[14]. To reiterate, 'value' only exists in relations between commodities and only gets expressed materially in the contradictory and problematic form of the money commodity.

The effects of exchange-value

The development of exchange-values presents an opportunity for the '*fetishism*' of commodities creating a fantastic reversal of value, in that things appear to be more valuable only in so far as they have the power to confer value. As owners of commodities human beings tend to become simply carriers of economic processes since they enter into acts of exchange with one another, and this can obscure both their human form and the human form of society. At the same time economic processes are personified and take on human qualities e.g. the 'needs' of Capital, the 'drives' of production. It is as if we become objects, and objects develop human qualities. As individuals we become outcomes of economic processes, and we appear to enter into economic activity as if it were our nature.

Alongside this, capitalism increasingly produces isolated individuals who confront each other as a means towards their private interest, and they do this not only at the expense of the larger institutions of society, but also 'detached from their natural bonds which in an earlier historical period made them the accessory of a definite and limited human conglomerate.'[15] This individualism found its basis in Adam Smith's widely praised defense of the system of private interest and private enterprise in his 'The Wealth of Nations' (1776), and the effects of universal competition based on the private acts of individuals has cut deeply into the social fabric and into the form of the social attachments.[16] Common obligations, cooperative work and economic bonds, have been replaced by the independent pursuit of self-interest, free enterprise and private gain. Capitalism has reversed the process of human beings creating society, by making it appear as if society gives birth to us. Society now seems to be formed of objects and processes that appear independent of us humans, and which dominate over us. It forces us to confront something ready-made, which exists without our intervention.[17]

Surplus-value and Capital

Within the capitalist system, the only reason investors engage in what is called the 'Money-Commodity-Money' (M-C-M) circulation of Capital, is to have more money (value) at the end than at the beginning. What happens is that 'the value originally advanced… not only remains intact while in circulation, but increases in magnitude,

[14] Harvey D. A companion to Marx's Capital (2010) Verso p 37

[15] Marx K, The Grundrisse (1857-61). Penguin Books NLR 1973 p 83-84 transl. Martin Nicolaus

[16] Ibid. p20

[17] Marx K. Capital Volume 1 (1867) Penguin Classics 1990 p1054-1055

adds to itself a 'surplus-value', or is 'valorised' and it is this movement that converts it into Capital'.[18]

Indeed here finally perhaps is the correct definition of 'Capital'. For Marx, Capital is not a thing but a process, a process specifically of the circulation of values. These values are 'congealed'(erstarrt in German) in different things at various points in the process: in the first instance as money and then as a commodity before turning back into the money form. Capitalists produce use-values only in order to gain this exchange-value needed for valorisation.[19] The capitalist may not actually care about which or what kind of use-value gets produced as long as it permits that procurement of surplus-value. The aim of the capitalist is rather unsurprisingly 'unceasing movement of profit making'.[20]

Where does surplus-value (profit) come from?

It is clear that surplus-value has to be produced before it can be consumed, so it cannot simply be understood as a by-product of extra consumption. The answer to what has surprisingly been presented as a conundrum over the centuries is that surplus-value can be produced in three basic ways: i) it can be dug out of the ground or physically taken in some other ways to become 'property' to be exploited (primitive accumulation or accumulation by dispossession) ii) by the excessive rents of a 'rentier' and iii) by the exploitation of 'labour-power'. Labour-power is a special commodity unlike any other, in that it is the only commodity that has the capacity to literally create value. It is labourers whose 'socially necessary labour time' (see above) is 'congealed' in commodities, and labourers who sell their labour-power to the capitalist. In turn the capitalist then uses this labour-power to organise the production of surplus-value. In this system the labourer trades a Commodity (their labour-power) to obtain Money to buy Commodities (the C-M-C circuit) while the capitalist works in the M-C-M circuit mentioned above. There are therefore different rules for how they think about their respective situations; the labourer can be content with what appears to be an 'exchange of equivalents' because it is use-values that matter, but the capitalist has to solve the problem of gaining surplus-value out of the 'exchange of equivalents'.[21] It is control of the labourer and ownership of production that permits the capitalist to organise production to gain surplus-value.

So how is this apparently 'magical act of profit making' brought about? According to Marx 'moments are the elements of profit'[22] and capitalists seek to capture every moment of their workers time in the labour process. They do not simply buy a worker's labour-power for 12 hours, they have to make sure every moment of those

[18] Marx K. Capital Volume 1 (1867) Penguin Classics 1990 p 252
[19] Harvey D. A companion to Marx's Capital (2010) Verso p 88
[20] Ibid p 89
[21] Ibid p 102
[22] Marx K. Capital Volume 1 (1867) Penguin Classics 1990 p 352

12 hours is used at maximum intensity, and to do this requires 'supervisory systems'.[23]

Supervisory systems are used to control the organisation of 'time and space' of the worker; Foucault studied spatially organised 'disciplinary apparatuses' which use Bentham's (much lauded at UCL) panopticon[24] as their template. In books like 'Madness and Civilisation',[25] 'Discipline and Punish'[26] and the 'Birth of the Clinic'[27]- texts about asylums, prisons and clinics- Foucault develops arguments about the rise of a 'disciplinary capitalism' in which workers have to be socialised and disciplined to accept the spatiotemporal logic of the capitalist labour process. To be a 'normal' person under this ideology is to accept a certain kind of discipline convenient to a capitalist mode of production. But of course this should never be seen as 'normal' at all, as it is a purely social construct that arose during this historical period in this particular way out of these particular reasons. It is not the only way that society can be organized.[28]

Another issue is that capitalism, in its pursuit of surplus-value, abhors limits of any sort and, precisely because the accumulation of money (social power) is in principle limitless, capitalism perpetually strives to transcend all limits (environmental, social, political and geographical) and convert them into barriers that can be bypassed or circumvented; hence it is driven to create markets everywhere including in health and social care.[29]

The effect of competition

It is at this point that Marx would surely have said that 'the coercive laws of competition are merely a tool to secure capitalism's survival'.[30] In other words, in order to survive, capitalism requires the maintenance of competition to keep the expansion of surplus-value production tomorrow on track as a means to absorb the surpluses produced yesterday (continual growth). From this it follows that any slackening of those coercive powers, through for example excessive monopolies (state or private), will in itself produce a crisis in capitalist reproduction. It was the neoliberal counterrevolution in the 1970s that not only smashed the power of labour but also effectively liberated and unleashed these coercive laws of competition by all manner of stratagems such as the opening up of foreign-trade, deregulation and privatisations.[31]

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[23] Harvey D. A companion to Marx's Capital (2010) Verso p 142

[24] The Panopticon in The Bentham Project www.ucl.ac.uk/culture/auto-icon/panopticon

[25] Foucault M. History of Madness. New York, Routledge 2006.

[26] Foucault M. Discipline and Punish: the birth of the prison. Translated by Alan Sheridan, Vintage Books 1977.

[27] Foucault M. The Birth of the Clinic. Translated by Alan Sheridan, Pantheon Books 1973.

[28] Harvey D. A companion to Marx's Capital (2010) Verso p 149

[29] Ibid p 162

[30] Ibid p 331

[31] Ibid p 332

Competition for profit increases the need for spatiotemporal discipline, and also other methods, to get maximum work for minimum cost, and it is these issues that have brought about the development of Unions to protect the welfare and standard of living of workers. An argument could be made that companies themselves, or even government, would monitor and prevent harmful practices within Capital's 'disciplinary systems', especially any 'health-care' one; the health, well-being and careers of the labour force should surely be a priority? As individual human beings capitalists may care, but when they are forced to maximise profit, come what may, especially under conditions of competition, individual capitalists have no choice. 'Après moi le deluge!'[32] is the watch-phrase of every capitalist and of every capitalist nation - they literally cannot afford to care. So looking at these things as a whole, it is evident that what happens within the system does not depend on the will, either good or bad of the individual capitalist, as under free-market competition 'the inherent laws of capitalist production confront the individual capitalist as a coercive force external to them'.[33] It is competition that drives [capitalists] to make decisions on the basis of the rate of profit, for if they go to a bank to borrow money then the bank will make its decisions based on their rate profit.[34]

Competition is also the element of capitalism that is frequently said to drive technological development forward. It may seem counter-intuitive but within capitalism technological advances, since they are 'dead labour', cannot themselves produce value, although an individual company/investor can get extra 'relative' surplus-value because of a new technology- relative because competitors will with time catch-up (this is one type of relative surplus-value). However, once these technologies become generally used, they can then become a source of a second type of relative surplus-value, this time to the whole capitalist class. But this type of relative surplus value is produced only through declines in the value of labour-power i.e. at the expense of the worker. So, in medicine for example, technologies will be used to break up what are seen as the 'monopoly skills' of expensive labour e.g. the Babylon algorithm replacing the diagnostic ability of the GP, or computer analysis in the reading of x-rays and scans. 'Capital therefore has an inherent drive and a constant tendency towards increasing the productivity of labour in order to cheapen commodities and by cheapening commodities to cheapen the worker them-self'.[35]

Capitalism is so incredibly technologically dynamic because of the two forms of relative surplus-value. Since capitalists are interested in the mass of surplus-value, and since they would generally prefer to gain relative surplus-value rather than confront struggles with workers over absolute surplus-value (involving wage cuts,

[32] 'After me the flood!' Stated by Louis XV of France after losing the battle of Rossbach in 1757, demonstrating a lack of care about what happens to France after his death. Used by Marx to indicate Capital's recklessness of the health or length of life of workers except under compulsion from society.

[33] Marx K. Capital Volume 1 (1867) Penguin Classics 1990 p 381

[34] Harvey D. A companion to Marx's Capital (2010) Verso p 131

[35] Marx K. Capital Volume 1(1867) Penguin Classics 1990 p 436-7

longer working days etc.), then any 'fetish' belief in a 'technological fix' as an answer to their ambitions is all too understandable.[36]

The idea of 'subsumption'[37] and the NHS

Capitalism did not just suddenly happen, indeed the free-market has only slowly been introduced into the NHS, as opposed to social care when, under Margaret Thatcher, large percentages of residential care placements were suddenly required by law to be provided through private companies. The changes in the NHS from 1951 to date can be seen as if it were an abbreviated (albeit staggered) history of the capitalist era.[38]

At first, the subjection of labour to capital was only a 'formal' result of the fact that the worker, instead of working for themself, worked for and consequently under the capitalist. So in the NHS certain services have been outsourced to private providers and an internal-market created to act as if NHS providers were 'independent businesses' with control totals to be met or else they would have to take out interest-bearing loans from the Department of Health and Social Care i.e. they (public bodies) have to take out loans from the very organisation (public body) to which they owe public money! Public services compete with private sector providers for some contracts. Organisations can 'go under' and be taken over by NHS England or Improvement personnel to 'pull them back' to financial balance. Patient care (and unfortunately safety) may on occasions take second place to the process of financial balance, and thinking about previously 'unthinkable' cuts in service provision has been encouraged[39].

As time goes on, through the cooperation (obtained with or without full-knowledge of the 'bigger picture' and encouraged through target driven financial bonuses and/or career continuation or progression) of numerous assenting employees, the command of capital develops into 'a requirement for carrying on the labour process itself, and into [what is termed] a 'real' condition of production.' There is an important distinction here, which is between the 'formal' subsumption of labour under capital versus its 'real' subsumption. It is only when labourers are brought into a collective structure of cooperation such as a 'factory', or with modern data technology a 'virtual' factory across a specified service, for a wage that both they and the labour process are under the direct supervision of the capitalist, and this is 'real' subsumption.[40] So the 'formal' process has been developing in the NHS for several decades, is out

[36] Harvey D. A companion to Marx's Capital (2010) Verso p 169

[37] A term for the process of absorbing Labour into the 'discipline' of Capital.

[38] See appendix for abbreviated timeline of policy changes in the NHS

[39] Campbell D and Hopkins N. Leak shows 'devastating' impact of planned NHS cuts in London. The Guardian 20 Jun 2017

[40] Marx K. Capital Volume 1(1867) Penguin Classics 1990 p 1019-25

there and ongoing, while the 'real', as if inside the factory under the supervision of the capitalist, will occur with the development of Integrated Care Systems (ICS)[41] a form of 'value-based' health system that is set up as an 'accountable care' structure. These systems will be separate, potentially private, business-like entities with central control, from which the activities of healthcare workers can be monitored and controlled against a single budget to provide care for their local population, and thus they will have the ability to generate surplus-value from public and private payments and investments. Whilst generally, 'real' subsumption entails more start-up costs and more initial capital, which makes it a riskier proposition for any private organisation, much of the infrastructure has been provided by the taxpayer alone or in partnership with private companies and investors, and this makes them a more attractive proposition to run- especially for already well-established private accountable care providers.

To repeat the assertion, when labourers are brought into a collective structure of cooperation they come under the directing authority of the capitalist because any cooperative endeavour requires some authority, much as a conductor directs an orchestra. It is the 'accountability' of the entire workforce to meet the single annual budget control total of the population served by an ICS, that forces employee cooperation. Furthermore, as Marx states 'as a specific function of capital the directing function acquires its own special characteristics.' As discussed above, this function is to recognise that 'moments' are the elements of profit and to squeeze as much labour time out of the labourer as possible. The capitalist takes control and '…..the interconnection between their various labours confronts (the labourers), in the realm of ideas, as a plan drawn up by the capitalist, and, in practice, as [this other's] authority, as the powerful will of a being outside them, who subjects their activity to their purpose'.[42] Success requires a structure enabling a process of 'direct and constant supervision of individual workers and groups of workers', a certain structure of supervision which is both authoritarian and, with the demand to produce surplus value, potentially 'purely despotic'.[43]

Since the author first worked in medicine the control of management over clinical organization and activity has grown; with accountable care it will escalate even further, with centralised control working with specially set-up local teams gathering and processing huge amounts of performance data, and monitoring and amending staff performance.

[41] Forty-four 'Sustainability and Transformation Plans' covering the whole of England were set up to develop their geographic area towards 'Integrated Care Systems' and then possibly 'Integrated Care Providers'.

[42] Marx K. Capital Volume 1(1867) Penguin Classics 1990 p 450

[43] Ibid.

The new workforce

Within the subsumed system, workers are 'divided, classified and grouped according to their predominant qualities,' and the result is 'a hierarchy of labour- powers to which there corresponds a scale of wages'.[44] The distinction between skilled and unskilled labourers becomes particularly marked, so that alongside the gradations of the hierarchy, there appears the simple separation of workers into skilled and unskilled; for the unskilled the cost of training vanishes; whilst for the skilled, with standardisation individual skills diminish, compared with what was required and in both cases the value of labour-power falls. Thus capitalist reorganisations and reconfigurations of tasks tend to produce deskilling, as tasks that were once complicated become simplified into component parts.

All this has the effect of reducing the value of labour-power employed and in particular 'the disappearance or reduction of the expenses of [training] directly implies a higher degree of valorisation of capital; for everything that shortens the necessary labour time required for the reproduction of labour-power, extends the domain of surplus labour'.[45]

Within the system there is a new working-class. It is stratified according to both status and the differential financial reward attached to the different functions required to constitute the 'disciplinary apparatus', and that then ensures the cooperation essential for the production of surplus-value. Whilst medical doctors, as many other professionals, used to think they were not part of any proletariat, it is not too hard to identify an insidious process of change in the medical workforce similar to that seen in schools and Universities, as the corporatist and neoliberal model becomes more entrenched.[46] Leadership positions, especially entrepreneurial leadership, are increasingly encouraged by NHSE among members of the medical and nursing professions. These may be associated with the bonus of extra money given as 'excellence awards', extra paid sessions, or new job titles with an increased salary and pension. Those with sufficient resources may personally invest in new developments and set up companies. Others are useful to capitalists by acting as Clinical Managers with target-driven attached bonuses.

The concept of 'real' subsumption applies to 'everyone caught within the factory walls'. How else could senior clinicians be persuaded to refuse life-changing care to people? Such decisions alleged to have been made in American Health Management Organisations are emotively revealed in John Pilger's 2019 film 'The Dirty War on the National Health Service'[47] and Michael Moore's 2007 film 'Sicko',[48]

[44] Marx K. Capital Volume 1(1867) Penguin Classics 1990 p469

[45] Ibid p 470

[46] Collini S. Speaking of Universities London, Verso 2017

[47] 'The Dirty War on the National Health Service' (2019) Director John Pilger. Dartmouth Films Production

[48] 'Sicko' (2007) Director Michael Moore. Producers M. Moore, M. O'Hara, S. Price.

and there are also academic papers from New Zealand reporting the numbers and outcomes of socio-economically deprived people who senior clinicians are not allowed (within the system) to operate on despite the clinical opinion that these people will gain as much benefit from a hip operation as patients that they are allowed to operate on.[49] [50]

Algorithms and policies will continue to multiply, patients' entry criteria and interventions will be standardised so that absolutely everything can be costed. Contact with expensive services will be minimised, and alternative, less expensive interventions 'innovated'. Recovery goals will be set, in order to limit 'episodes of contact', and fragmentation of care delivery into 'functional' units will hasten customer 'pull' through services. Boxes will be ticked. The expensive 'monopoly skills' of professionals will eventually be totally broken. Workers will 'lose their personhood and become a mere part of variable capital'[51]. This is what Marx means by the 'real' subsumption of the labourer under capital.

What does Capital want from psychiatry?

To produce Surplus-value

Currently 30% of adult mental health hospital capacity is now in the private sector, and revenue growth is 'robust', though pressure on prices by financially stretched NHS agencies has meant some diminution of profit margins.[52] In Child and Adolescent mental health 44% of NHS expenditure is on services provided by the independent sector.[53] The market for mental health services was worth £15.9 billion in 2015 and the private hospital sector had grown by 8% in the previous five years while NHS capacity had been cut by 23%.[54]

Private investors will want to make more surplus-value, and governments competing in the global capitalist arena will want to spend less on healthcare; both will want reductions in state-funding of services year on year, and will also want to develop health provision for self-paying customers; so further breaking down any state

[49] Blackett J et al. The impact of the 6-month waiting target for elective surgery: a patient record study NZMJ 2014 Vol 127 No 1405

[50] Anitelea T et al. The outcomes of patients returned to general practitioner after being declined hip and knee replacement NZMJ 2017 Vol 130 No 1464

[51] Harvey D. A companion to Marx's Capital (2010) Verso p 175.

[52] Independent mental health hospitals buoyant and enjoying robust demand. Laingbuisson.com Press release Feb 2018

[53] Mental Health Services: Children and young people: written question 191398 14th November 2018. www.parliament.uk

[54] Cygnet Health Care and Cambian Adult Services; a report on the completed acquisition by Cygnet Health Care and Universal Health Services Inc. of the Cambian Adult Services Division of Cambian Group plc. Competition and Markets Authority Oct 2017

monopoly. If health care is to continue to be available then Capital would demand a focus on maintaining economically active (valuable) citizens to provide sufficient human labour-power. Much of health care is labour intensive and currently cannot be replaced by technology. It is therefore inevitable that the relative terms and conditions of workers' employment will worsen, and the availability of highly skilled (monopoly) workers to patients will be minimised and substituted by less skilled workers with the help of technology and other techniques.

Another feature inherent in capitalism to generate profit is that of 'production for production's sake' or production as an end in itself. This occurs because as soon as the exchange-value of any product becomes the decisive purpose, it generally becomes the direct purpose to produce as much and as large surplus-value as possible. It is production which is not limited by any predetermining or predetermined barriers set by needs. Internationally there have been massive growths in psychiatric diagnoses and recommendations for different medications[55] – initially in the US, but now it appears to be coming to the UK – e.g. the suggested treatment of adult ADHD, or the 'medicalisation' of what would otherwise be considered non-psychiatric behaviours such as 'shyness' or vague concepts such as 'happiness' or 'wellbeing'.

To capture 'moments'

In Marx's view: 'a 'craftsperson' who [in order to complete a task] performs various partial operations must at one time change their place, at another time their tools. Such transition from one operation to another interrupts the flow of labour and creates gaps in the working day, so to speak'.[56] Capital does not like such gaps, since moments are the elements of profit, and these gaps close up when the worker is tied to the same operation the whole day long. In the service where the author worked, there used to be: 'key-workers' providing continuity and support for their patients; single assessments (to prevent unnecessary repetition); 'seamlessness' with preservation of the key-worker relationship across service structures; multidisciplinary working with teams full of highly trained professionals; and career progression within the service. This was all dramatically changed with the creation of 'functional' units concentrating on parts of the 'patient pathway'; 'service-lines' for patients based on their expected 'resource cost' to the service; time-limited episodes of care with arbitrary recovery points; and reduced amounts of support, with such support reframed as 'damaging to the patient's ability to help them-self'. In psychiatry, where diagnosis is syndromal, and management and resource needs within a given diagnosis are highly variable, it is easy to see how Capital's need for economic tools of resource equivalence and their application could negate

[55] Frances A, DSM-5 is guide not bible-ignore its ten worst changes. APA approval of DSM-5 is a sad day for psychiatry. Psychology Today 2nd Dec 2012

[56] Marx K. Capital Volume 1(1867) Penguin Classics 1990 p 460

psychiatry's long struggle to get to the high level and quality of 'user-friendly' patient care and support it managed to achieve, in the author's experience and belief, in the two decades before the economic crash of 2008.

To commodify patients

Recent reorganisation of psychiatry in the NHS has been constant, moving from acute trusts to community trusts, and thence to mental health trusts, followed by foundation trusts. The most extreme change suggested however has been in service delivery designed around the ability to cost customer groups i.e. to commodify patients.[57] This involves 'cluster' development[58] with associated standardised management, where the sorting of customers into 'resource-use' similar groups becomes a major priority at initial contact with a patient because the financial integrity of the service depends upon it. 'Clusters' will remain an important part of the new methods of payment (episodic or capitated) associated with the ICS developments.[59] At the same time the primary interest in choice of outcome measures moves to ones that are practical and can enable comparison between the 'value' of different ICS service activities, and so foster competition and continually try to innovate to reduce costs.

To reduce contact with highly-skilled workers

Relations of production affect relations with patients (cf. social); we are increasingly asked to call them 'users', 'consumers' or 'customers'. While this may benefit the individual patient who feels empowered in their relationship with a 'distant' professional, there is no understanding of how it may affect the professional's behaviour to the new 'customer'. But then in this 'society of the individual', where self-containment and value rule, there is renewed concern that our customers may become 'dependent' and harmed in some way by continued contact with our services, which in some way hinders their ability to 'recover' and reach their true potential.[60] It happens also to be expedient to Capital not to allow relationships with professionals to develop, but to move 'customers' through services within costed parameters, and to reduce inpatient or hospital outpatient facilities while increasing less expensive community interventions while encouraging self-care.[61]

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[57] Self R, Painter J, Davis R. A Report on the development of a Mental Health Currency Model (including suggestions on the development and testing of PbR tariffs) South West Yorkshire Mental Health Trust Prepared for the DoH April 2008

[58] Trevithick L, Painter J, Keown P. Mental health clustering and diagnosis in psychiatric inpatients. BJPsych Bull 2015 p 119-23

[59] New payment approaches for mental health services; support for commissioners and providers of mental healthcare to shift to new payment approaches. NHS Improvement updated Jan. 2017. Improvement.nhs.uk accessed June 2020.

[60] Shepherd G, Boardman J, Slade M. Making Recovery a Reality. Sainsbury Centre for Mental Health 2008.

[61] nhslongtermplan.nhs.uk

The de-professionalisation of workers within mental health is a form of exploitation. In the author's experience employers 'split' the workforce to help to achieve their aims. Doctors and psychologists, particularly those in managerial roles, were encouraged by the CEO and their team to support the proposed action to make the rest of the work force redundant, only to re-interview people for their own jobs, or another similar job, at a lower salary. Management was also able to find agreement amongst other disciplines that not all 'nurses' needed the expensive training they have in order to do the work involved, because many of their tasks, when broken down, were 'simple' and 'could be done by untrained non-professionals if they are keen and bright'. The Trust decided to further the attack on nurses by calling all team workers, trained and untrained, generic 'mental health professionals.'

Because of excessive workloads creating burdensome clinical and legal responsibilities as Responsible Officers, doctors in psychiatry had already agreed shared responsibility for some roles within multidisciplinary teams. The supervisory role of the Consultants would be extended with increasing pressure on the team to assess and manage as many 'customers' as cheaply as possible. There is a future possibility that the doctors may only need to be employed part-time in a supervisory capacity in the public sector, enabling them to sell their clinical skills within a burgeoning private or paying-NHS sector.

A move away from idiographic approaches

Capital collapses space for 'independent thought' between the guidelines, standardised activities, computer data entry and the time restriction for patient work; there is little room to consider the patient or 'customer' in their context. Intangibles such as empathy, genuineness and trust, which as human beings we accept as important factors, are not easily measured or costed, and therefore not of particular interest. Indeed the collection, understanding and employment of a detailed life history, once seen as a cornerstone of psychiatric education and practice, seems to be no longer valued as a priority.[62]

Standardisation and discipline

Workers are to increasingly become 'appendages of a machine'- they follow guidelines, protocols and algorithms, measure pathology using questionnaires, employ manualised interventions, collect satisfaction questionnaires from customers, and enter all details into ever growing computer software packages used to performance-manage individual workers and teams. Job satisfaction increasingly centres on job title, power within the service and money, with people promoted to manage the system rather than to deliver clinical care.

[62] Cawley RH. Psychiatry is More Than a Science. British Journal of Psychiatry (1993), 162, 154-160

While there are professional bodies and NHS contracts that oversee conduct and performance, Capital's need to command and control requires that the worker contract is also tied in to individual and service production targets. Thus individuals may lose career progression or their job if their 'customers' do not meet targets in sufficient numbers, or if the service line organisation, or the bigger accountable care organisation they work for do not meet their three, or five, or ten year targets and they in turn fail to regain their contracts. This discipline of meeting financial targets is therefore set in the workers' minds and will influence all their actions and decisions about individual 'customers'.

To reduce bed use and sell-off buildings and land

Finally, there is a special role for 'capital accumulation by dispossession' within the NHS which has been occurring in psychiatry for years. The service, its infrastructure and resources belonged to the people. We owned it. Slowly, buildings, land and workers have been transferred to private businesses and corporations, sold off to meet a constant drive for efficiency savings. In the author's experience this initially involved the sale of the large Victorian asylums in the 1990s, with many long-term patients moved into 'staffed hostels' in the community, with high quality Psychiatric Day-Centres, Drop-in-Centres, Day Hospitals and provision of smaller inpatient units. At the time this appeared a positive move, especially given the extreme neglect of the fabric of the asylum buildings. However, with time the levels of supervision in the community facilities were reduced, then patients, having been told that their placements were for life, were moved out of hostels into council, charitable or privately rented bedsits or flats- allegedly to fit in with a process called 'normalization', but again bringing savings in the care budget. Following this, the Day Centres and other psychiatric facilities were closed and patients were given 'personal budgets' to plan and purchase their own care and interests within the available generic community facilities- further savings. This 'discharge and close' programme funneled assets away from the state, and money from people's pockets, to private enterprise.

The proposed major reorganisation and transformation of the NHS into ICSs, with less expensive community alternatives for hospital referrals or admissions, seems to parallel the earlier changes in psychiatric services, and depends heavily upon further Capital released from efficiency savings of NHS estate and the sale of allegedly 'surplus' land and buildings. This 'surplus' estate has been valued Nationally at over £3bn, and its sale has been driven by the Carter Report,[63] the 'Cabinet Office-driven' One public estate[64] and the Naylor Report.[65] This is pure capitalism; state

[63] Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: unwarranted variations. February 2016 assets.publishing.service.nhs.uk

[64] The Right Hon. Ben Gummer (The Cabinet Office) More than 150 Councils join the One Public Estate Programme. Press Release. October 2016 www.gov.uk

[65] Sir Robert Naylor. NHS Properties and Estates. Why the estates matter for patients. An independent report for the Secretary of State for Health. March 2017 assets.publishing.service.nhs.uk

assets being used to finance the creation of ‘cooperating groups of workers in value-based health systems’ (factories) appropriately set up with the potential for the creation of surplus-value.

Summary

The practice of science is not immune to the effects of ideology. Medicine, but in particular psychiatry with its reliance on syndromes and its lack of biological markers, is not a pure science and this may make it even more susceptible to political and societal influence. The current paradigm of neo-liberal capitalism is not simply a ‘best value for money’ mind set. It is an ideology and system that completely overturns human relationships, objectifies humanity and animates commodities; it dictates behaviours with its demand for the surplus-value required to maintain itself.

The abstract nature of ‘value’ with its ‘crystallisation’ in the money commodity; the infinite potential and the social power of that money commodity; the creation of surplus-value requiring the exploitation of workers and accumulation by dispossession; the ever-increasing wealth for the owners of the means of production and investors, with continuous pressure in the system to heighten the exploitation of workers; all these create gross inequalities. This is relevant to psychiatry, not only because of the associated mental distress and unhappiness within the population, but also because of the ever increasing economically defined limitations on the management of that distress.

The facts that there are people with enduring mental distress who have great difficulty earning a living in the competitive marketplace, and that there is a move towards a ‘value-based’ health system by an hegemony which demands ‘surplus-value’, suggests that there are areas of psychiatric services that are likely to be incompatible with that hegemonic ambition. It is likely that within a ‘value-based’ health system (such as an ICS with a fixed annual budget) when choices have to be made, those interventions that improve health and decrease costs, or indeed generate wealth, for the system will receive priority. Helping people who have physical problems and secondary mental distress, and addressing the physical health of all people with mental health problems seem to be current priorities. This is probably because, while addressing need, they may also reduce service use and expenditure elsewhere in the health system. However, the current economic paradigm predicts that the lives of people with severe, enduring mental health problems are likely to remain blighted by the lack of adequate state financial support, housing and services.

The inclusion of psychiatric services within the fast approaching Integrated Care Systems will place them ‘in the factory’. Psychiatry will then be judged on the ‘value’ it provides compared with all the other health and care services required to meet the needs of the ICS population within a single capitated budget-psychiatric services will

come under the aegis of ‘real subsumption’. With increasing pressures over time to do more for less money within each Integrated Care System, difficult decisions about what is most valuable for the running of the system as a whole, and its competitiveness measured against the 40+ other systems, will have to be made. We will then discover the true ‘value’ Capital places on psychiatry and our patients.

Appendix:

A Timeline for ‘formal’ subsumption by Capital in the NHS. (modified from NHS reform timeline nuffieldtrust.org.uk)

1. As a first retrench, in 1951 prescription, dental and spectacle charges were levied.

2. A dispute over medical remuneration in 1960 led to the government threatening a phased withdrawal from the NHS.

3. Sir Keith Joseph’s amendment of the ‘Crossman Plan’ for reform in 1971 put major elements of management consultancy into the NHS.

4. The ‘Griffith’s Report’ 1983 strengthened the role of managers within the NHS moving away from earlier consensus management systems.

5. The ‘Cumberledge Report’ 1987 brought extra payments to GPs who provided specific services, and the creation of integrated care ‘shops’ inspired by Health Management Organisations (HMOs) in the US.

6. ‘Promoting Better Health’ 1987 increased ‘patient choice’ by widening services provided by nurses and pharmacists in the community, and brought in medical audit and introduced hospital Trusts for ‘able’ hospitals.

7. The ‘NHS and Community Care act’ 1990 created the ‘internal market’ with ‘purchasers’ (mainly health authorities) ‘providers’, and GP ‘fundholders’ able to take on their own budgets and purchase services directly.

8. ‘The Patient’s Charter’ 1991 introduced targets for waiting times for treatment. ‘Provider PerformanceTables’ were introduced in 1994.

9. ‘The Tomlinson Report’ 1992 recommended rationalising, merging and thereby increasing the efficiency of health provision in London by closing up to 13 hospitals-in the end after ‘push-back’ only the Middlesex Hospital was closed.

10. The ‘Health of the Nation’ 1992 reduced the number of regional health authorities to eight.

11. With the ‘NHS Plan 2000’ Private Finance Initiatives (PFIs) were used for the first time to design, build and operate hospitals.

12. The ‘Commission for Healthcare Improvement’ was created in 2001 to formally assess the performance of NHS hospitals. There was the introduction of the hospital star rating system in 2001(later scrapped in 2005).

13. ‘Shifting the Balance of Power’ 2002 abolished 95 health authorities and replaced them with 28 strategic health authorities (SHAs) and 303 Primary Care Trusts (PCTs) responsible for 80% of the NHS budget.

14. The ‘Health and Social Care Act 2003’ established semi-autonomous NHS Foundation Trusts, the Commission for Healthcare Audit and Inspection, the Commission for Social Care Inspection, and focused on the recovery of NHS charges.

15. The Government outlined plans to devolve commissioning from PCTs to local GP practices in 2004.

16. ‘Choosing Health’ 2004 reiterated the wish to promote individual responsibility in health, supporting choice, personalised services and working between public and private sectors.

17. An NHS reorganization in 2006 reduced SHAs from 28 to 10 and PCTs from 303 to 152. PCTs frequently merged to reduce overhead costs thus reducing their ties to specific individual communities in the interests of efficiency.

18. ‘Our Health, Our Care, Our Say’ 2006 encouraged patient choice and the movement of services out of hospitals into community services.

19. ‘NHS autonomy and accountability: proposals for legislation’ 2007 suggested scrapping the ‘target culture’; reducing red tape; giving patients the power to decide how they should be treated; handing day-to-day control to an independent board; putting senior doctors in charge of local budgets with power to say how NHS money is spent; allowing patients to be able to secure treatment at their hospital of choice, whether private or public sector, as long as care was delivered at NHS cost.

20. In ‘Healthcare for London: a framework for action’ 2007 clinician and Labour minister Lord Darzi suggested moving provision of routine health care closer to people’s homes; centralizing specialist care services; developing academic health science centres (set up as plcs); creating polyclinics with resource for minor procedures, urgent care and x-rays.

21. The ‘Care Quality Commission’ was created in 2009 by merging the three existing regulators (Healthcare, Social care and MHA) and covered the NHS, Local Authorities, private companies and voluntary organisations.

22. The ‘Nicholson Challenge’ 2009 sought efficiency savings of £15-20 billion between 2011-2014.

23. The white paper ‘Equity and excellence: liberating the NHS’ 2010 shifted responsibility for purchasing care to groups of GPs; demanded shared decision-making for patients; promised increased patient control of their care records and information to make choices; offered increased choice; enabled patients to rate hospitals and departments; set up Healthwatch a new consumer champion; wished for a focus on outcomes; required NHS quality of care and payment system standards developed by NICE; wished money to follow patients to support patient choice; wanted to pay providers according to their performance; planned to

empower professionals and providers giving them more autonomy and making them accountable for their results; asked local authorities to promote the joining up of local NHS services, social care and Health Improvement; aimed to create an independent and accountable NHS commissioning board and to create the largest social enterprise sector in the world; promoted effective and efficient providers through competition, price regulation and the safeguarding of continuity; sought £20 billion of efficiency savings by 2014; wished to reduce management spend by 45%; radically wanted to reduce the DoH's functions and to abolish QANGOs.

24. All in 'Liberating the NHS' eventually came into fruition with the Health and Social Care Act 2012.

25. Industrial action by doctors in 2012 against Government changes to reduce their pension benefits.

26. The 'Mandate to the NHS Commissioning Board' commits it to decentralisation and local decision making.

27. In 2013 NHS England (NHSE) and 211 Clinical Commissioning Groups (CCGs) were set up, with a number of Commissioning Support Units (CSUs) to provide business functions; SHAs were abolished; four regional and 27 local branches of NHSE ensured the policy direction in their areas.

28. In 2014 Simon Stevens moved from UnitedHealth to become CEO of NHSE. The Five Year Forward View (FYFV) 2014 was published to meet an estimated £30 billion funding gap by 2020/21. It used plans developed by Simon Stevens while he was at UnitedHealth, and co-produced with McKinsey using their 'World Class Health Service' plan full of financial efficiencies developed for the Labour Government and 'buried' by them in 2009. His plan was in essence presented at WEF in 2013. It would make savings by: developing less expensive 'closer to home care' to replace as much expensive hospital activity as possible; reducing elective secondary care referrals by comparing service activity across geographical areas and bringing all services to the 'minimum comparable number' otherwise known as removing 'unwarranted referrals'; using less expensive technology where ever possible; using technology to collect large datasets to help identify people 'at risk' of admission and targeting them for increased care; furthering attempts to reduce population morbidity, particularly by encouraging individual responsibility for behavior changes; developing psychological care for people with Long Term Conditions, and preventive physical care for people with severe enduring mental health problems, to reduce their high-level of healthcare service use,.

29. In 2015 Manchester became the first English region to get full control of its health spending. This came with extra finance to kick-start its 'closer to home' care.

30. Seven day access to GPs was pledged in 2015.

31. Due to the perceived threat of a deterioration in terms and conditions of working, Junior Doctors went on strike in 2016 but eventually gave way the same year.

32. The 'Cities and Local Government Devolution Bill' 2016 allowed Secretaries of State to remove duties and powers from public bodies, including NHS Trusts and commissioners and

transfer them to local councils or combined city authorities like Manchester; uncertainties about the potential use of this Bill remain.

33. NHS Improvement was formed in 2016 with regulatory and oversight duties over all NHS Providers.

34. Forty-four draft 'Sustainability and Transformation Plans' were submitted in 2016 with multiple CCGs and Trusts led by one local Accountable Officer.

35. Plans to regain control of NHS finances in 2016 included a 'special measures' regime for underperforming hospitals, controls setting the amount Trusts can spend and access to extra Transformation funding pinned to financial targets and clinical performance.

36. The 'Next Steps of the Five Year Forward View' 2017 wished to take the strain off A&E by dealing with up to 3 million visits in the community using: new 'Urgent Treatment Centres'; an increased availability of GPs; and more nurses, doctors and paramedics triaging NHS111 calls. 2-3000 hospital beds were to be freed up by expediting discharges; primary care multi-disciplinary teams were to be developed; more people would receive 'talking therapies' for common mental health conditions and more people with severe enduring mental illness would receive physical health checks; the old CCG areas would be encouraged to integrate their services with Local Authorities and funding was to be used to move the NHS towards the development 'accountable care systems' (the term was later dropped for PR reasons); further efficiencies would be required with the 'NHS 10 Point Efficiency Plan'.

37. A new contract for general practice was agreed in 2019 for the development of multidisciplinary Primary Care Networks (PCNs) with money for their creation and a new quality improvement domain with performance on service specifications measured on a new national 'network dashboard'. Networks successfully reducing emergency hospital activity or over-prescribing would be financially rewarded; access to primary care would be via digital technology with online booked appointments; patients were expected to have access to video consultations by 2021.

38. The 'NHS Long Term Plan' 2019 wanted to achieve a host of clinical improvements by the development of 'Integrated Care Systems (ICSs) combining commissioners and Trusts; there would be new legislative powers to 'pool' local powers, loosen competition requirements, and combine the activities of NHSE and NHSI; an increased proportion of the health budget would be directed to out-of-hospital care via PCNs; the use of Personal Health Budgets would cover 2.5 million people by 2023; outpatient attendances would be reduced; CCGs would be merged into a single ICS commissioning group and locally Integrated Care Partnerships (ICPs) would develop to bring together PCNs in the footprints of local authority services; the deployment of digital tools would be expanded.