WHAT IS SOCIAL POLICY?

- Introduction
- The discipline of social policy
- The changing nature of social policy
- The mixed economy of welfare
- Perspectives on welfare: the influence of ideology
- Models of welfare states
- Criticisms of state welfare
- The development of the welfare mix in Britain
- Social policy and social goods
- Social policy: a contemporary analysis
- Conclusion
- Summary
- Further reading

Introduction

Walk through any shopping centre and you immediately see that people are different – different ages, race, ethnicity and sex. These are obvious ways that people are different. But there will be other factors that are not so obvious such as income, type of job or where they live. You may think that this is an obvious observation and what has this to do with health and social care professionals and delivering care services? The answer lies in how these differences appear, the impact they have on people’s lives and how society responds to them. Essentially these are social divisions and such divisions have real consequences for people in terms of how they live, their health, life expectancy and relationships with other people. In particular they are closely related to social inequalities and, for social policy analysts, examining how such inequalities arise and how they can be addressed are key concerns.

This chapter outlines the scope of social policy as an area of study and introduces the reader to major themes and issues within the discipline of social policy concerning the role of the state in the provision of welfare, the key actors in the provision of social welfare, the complex interactions between these providers and the influence of ideology on social policy. In particular, it explores the recent shifts in how social policy is conceptualized and highlights why an understanding of social policy is
important for understanding health policy and the delivery of health care services. Central to the current study of social policy is the recognition that society is divided by differences such as age, gender, income, ethnicity and so forth. Traditionally the focus has been on divisions of class (as discussed in the next section), but increasingly other key differences and divisions in society are being seen as important and relevant to social policy. It is recognized that these differences are the result of social processes and the acceptability of such differences varies within societies. In relation to health care, what is particularly important is the way these differences affect people’s health and experience of care. They are of central concern to the study of health.

The discipline of social policy

The discipline of social policy is relatively new, at least in comparison with other social sciences. The study of social policy began at the London School of Economics (LSE) in 1950 and was mainly concerned with the training of welfare professionals during a period of expansion in the welfare state. This led to a focus, within the discipline, on the statutory sector – on what the welfare state itself provided. Close links, between the then Labour government and Fabian socialists such as Richard Titmuss (head of the social policy department at the LSE), led to a demand for information to guide the future expansion of the post-war welfare state. The scope of the discipline in these early years was, therefore, strongly influenced by the institutional structures of the welfare state. Housing policy was primarily concerned with the development of public housing and health policy with the setting up of the National Health Service (NHS). Optimism about the prospects of the post-war welfare state’s ability to solve the social problems of the day and bring about greater social justice thus led to a very narrow disciplinary focus.

It was around this time that T.H. Marshall developed his work on welfare and social citizenship. Marshall argued that, prior to the welfare state, a person’s access to social resources (such as food, education and health) and their personal welfare depended primarily on their income from paid employment. Those with higher income (and/or wealth) could thus command greater social resources while those with low or no incomes went without (or were dependent on the parish for Poor Law support). The development of a system of social entitlement which derived from citizenship (or membership of a given society), irrespective of ability to pay, was, according to Marshall, the litmus test of a civilized society. The welfare state then, with its universal health service, pensions and state education, was to modify existing patterns of inequality, based on social class, and ensure that certain key social goods were available to all. The relationship between income from paid work and individual welfare was mediated by the introduction of collective social policies provided by the state. Academic concern then focused on the role of the state as the primary provider of welfare.
The changing nature of social policy

The discipline has since broadened considerably in response to a number of pressures. First, there has been increasing recognition of the role of other actors which contribute in important ways to individual welfare; it is not only the state which provides welfare and not all welfare professionals are employed by the state. Second, the role of the state in relation to social policy has changed considerably. Housing departments are now seen as enablers and facilitators of housing, working in partnership with the voluntary sector (housing associations and cooperatives), tenants and the private sector in the provision of new housing. Health policy, similarly, has become less concerned with the institutional operation of the NHS (although this remains an important area of policy) and has become more involved in performance management and commissioning to develop a more patient-responsive service with multiple providers in the public, private and voluntary sectors. Health policy has also increasingly been focused on public health issues, tackling inequalities and key health problems such as cancer, circulatory disorders, obesity, smoking, mental health and sexual health.

The discipline of social policy is thus no longer concerned solely with what the state itself provides in terms of welfare, but more broadly with the whole structure of social entitlement and social responsibility in society, which forms the basis of citizenship. Early concerns, regarding the narrow focus of the discipline, led Richard Titmuss to write an essay on the ‘Social Division of Welfare’ in 1955 (reprinted in Abel-Smith and Titmuss 1987). Titmuss drew attention to the contribution of two areas of welfare provision (in addition to that provided directly by the state), hitherto neglected in academic study: fiscal welfare (that provided for individuals via taxation policy), such as mortgage tax relief, and occupational welfare (welfare resources provided via employers to their employees), including various forms of occupational perks such as low-interest mortgages, crèches, company cars, tied housing etc. Titmuss argued that it was necessary to consider the contribution of all three sectors in order to understand the redistributive impact of welfare. While some aspects of state provision may indeed modify the relationship between income and access to welfare (e.g. universal free health care), the contribution of the other sectors may in practice compound existing inequalities as welfare entitlement increases with status. Occupational welfare, for example, typically benefits those in white-collar jobs and is often regressive; that is, the more you earn the greater the value of the ‘perk’. It was for this reason that Titmuss referred to occupational welfare as the ‘concealed multiplier of occupational success’.

Referring specifically to the development of occupational pension schemes, Titmuss noted that the cost to the Exchequer (in 1955) of such schemes was ‘substantially in excess of the cost of national insurance pensions … contrary to the intentions of the 1920 Royal Commission, which considered tax relief for such schemes appropriate for poorer taxpayers, the benefits have increasingly favoured the wealthier’ (Abel-Smith and Titmuss 1987: 50).

Recent changes to the pensions system, such as stakeholder pensions and the inclusion of property portfolios also, provided tax relief benefiting the
more wealthy rather than the poorest in society. The impact of modern welfare systems on social inequality is thus quite complex and requires an understanding not only of direct provision of welfare goods by the state, but also of the role of the state in other areas as a financier and regulator of policy.

Since the 1950s, it has become increasingly recognized that even this categorization is inadequate if we are to understand fully the redistributive implications of social policy. In addition to these areas of provision, we might add a further three: the contribution of the voluntary or not-for-profit sector (through agencies such as Age Concern, the National Society for the Prevention of Cruelty to Children and the Red Cross), the role of the commercial sector (through the purchase of welfare directly from commercial agencies) and, finally, the enormous contribution of informal care provided by families, neighbours and friends. Despite their importance historically in meeting welfare needs, these systems have been largely ignored or treated as marginal, as the focus of attention has been on the state provision of welfare services rather than on the influence of public policy more generally. It is important to remember that we are not talking simply about three parallel systems of resource distribution operating independently of the state, but of a complex relationship between the state and these sectors, which has profound implications for citizenship and the distributional implications of social policy. We are not simply concerned, then, with what the state itself provides, but how it uses the power and resources vested in it, to control and determine the whole basis of social provision through the regulation and financing of private and voluntary support. Clearly the broader aspects of public policy are important here (such as economic policy and taxation), but so too are areas of non-decision-making or policy vacuums. In many cases, the lack of provision is just as significant as policy intervention. Nowhere is this more evident than the way in which state welfare providers have, until recently, ignored and thereby failed to acknowledge the important and essential role of informal welfare – especially that which is provided by wives, mothers and daughters.

The mixed economy of welfare

It is important to recognize that the model of the UK government, as welfare monopolist or the main provider of welfare, is not and has never been a correct one. Not only does it ignore or marginalize the role of the private, commercial and voluntary sectors, but it also ‘naturalizes’ informal provision by families and carers – particularly women. Feminists in particular have pointed to the major contribution made by women to the provision of informal, unpaid welfare (Abbott et al. 2005).

Recognition of the complex and changing nature of the state, in contemporary welfare systems, has been reflected in the introduction of the concept of welfare pluralism or the ‘mixed economy of welfare’ in place of the term ‘welfare state’. This concept emphasizes the need to consider the contribution of a plurality of providers to individual welfare. Figure 1.1
illustrates the broader impact of public policy on individual access to welfare, and Box 1.1 illustrates how the mixed economy works in practice in the context of health care.

We can see from the above examples how a person’s health status – or their access to health resources – is dependent on a range of providers, all of whom are influenced, to a greater or lesser extent, by public policy. Moreover, our health status depends not only on what is construed as ‘health’ policy specifically (as in the example above), but also on many other aspects of social policy. There is a range of policies that have important implications for personal health status, including policy on the environment, on housing, employment and education. Indeed, the main cause of childhood mortality is accidental death, often as a result of proximity to road traffic, lack of adequate play areas and poor environmental planning. Employment status also has an important impact on personal health (see Chapter 5).

Figure 1.1  Public policy and individual welfare.
Box 1.1 Provision of health care by the six welfare systems

The service provided by the NHS is statutory welfare, as is, for example, the provision of sports and recreational facilities/services – they are provided directly by central or local government. Examples of fiscal welfare (welfare promoted through the taxation system) include tax incentives for older people to subscribe to commercial health schemes. Voluntary provision includes the contribution of organizations such as the Macmillan Foundation, which provides nurses for cancer patients, or the hospice movement for the care of people who are terminally ill. (Charities such as these also benefit from certain forms of tax relief; that is, they benefit from fiscal policy as well.) Occupational schemes include the provision of private health insurance, health education classes and sports facilities by employers for their employees. Some employers, for example, provide their own antenatal classes for pregnant employees. The informal sector is responsible for many areas of health care, including the care of people at home (by family and friends), the provision of transport to hospital and educating children about health care. Commercial health care includes the buying in of private nursing care at home as well as purchasing in- or out-patient hospital treatment, or paying for homeopathy, physiotherapy or acupuncture as a supplement to, or a substitute for, NHS provision.

Health is not something separate from the rest of the social context: it is inextricably bound up with income, housing, education and every other facet of public policy. There can be no lasting good health without income adequate to provide the required diet and clothing or without adequate housing and the means to heat it. Health is improved and health inequalities diminished not just, or even primarily, by attention to health – housing, income and all the other aspects of welfare, are just as likely to be in need of attention and to be capable of making a contribution to the health of the populace. A situation that has increasingly been realized by successive governments in relation to public health policy (Baggott 2000). A similar point could be made about any branch of welfare provision.

Thus, while it is important for health professionals to understand the history and philosophy of their own service, in order to locate current practice in its context and to understand current trends, they also need to understand the contribution of other aspects of policy and the role of other caring professions. Provision for children with special educational needs (SEN) provides a useful example of the need for welfare professionals to be aware of their respective roles and services, in order to plan effectively to meet the complex physical, psychological and educational needs of this group of children.

So far, we have seen how the scope of social policy extends to all aspects of the mixed economy of welfare, of which the welfare state is only one component. We have emphasized the fact that welfare pluralism is nothing new. In Britain after the Second World War, there was already a mixed
The modern welfare state has been seen as a benchmark of a civilized society, altering the basis of social entitlement from one simply of ability to pay, to one based on some notion of citizenship (Marshall 1975). However, neither Marshall nor Beveridge expected to eliminate social inequality in this process, but they did want to reduce the effect of such disparities on people’s access to basic social goods. Thus the introduction of comprehensive, free health care would result in a broad equality of health status, and a universal education system would produce a broad equality of life chances or equality of opportunity if not of outcome. Under such conditions, the persistence of other aspects of inequality in society would be both tolerable and legitimate – on the grounds that those with greater income and wealth had achieved it via greater effort or ability.

Marshall’s vision of the welfare state was one of a redistributive system promoting social justice and consensus, but in practice this has not necessarily occurred (Powell 1999). Also, the notion of a welfare state as redistributive, fulfilling broader moral objectives, is not universally accepted. It is important to be aware of the extent to which policy-making and implementation are part of a wider political process, which is affected by both political expediency (often, electoral considerations) and ideology (a set of more or less coherent ideas about the way in which social welfare should be organized). Ideas about the role and function of the state in social policy (and particularly about the nature of the welfare state itself) are conditioned by and reflect specific moral, political and ideological positions about the causes of social problems and the apportionment of responsibilities. Where social problems, such as unemployment, ill health or poor housing are interpreted as the fault of individuals (a reflection of personal failure), there may be some question about the responsibility of the state to rectify the problem. Indeed, it could be argued that, state intervention in such circumstances may be counterproductive, providing incentives for people not to work or to provide adequately for their
families, or to apply themselves to their studies. On the other hand, if social problems are interpreted as a reflection of the failure of the state itself, perhaps of its economic policy resulting in inadequate wages and lack of employment prospects, then it could be argued that the state has a responsibility to those in need as a result (subjects we return to in Chapter 2).

Much of the debate in social policy is concerned with ideas about moral responsibility and the meaning of citizenship, about when and how the state should assume responsibility and when it should be left to individuals and their families. The shifting nature of this debate and the dominance of particular perspectives over time has resulted in a reordering of the balance of responsibilities between the sectors involved in the welfare mix.

Models of welfare states

One of the first attempts to illustrate the impact of ideology on social policy, was Richard Titmuss' classical distinction between ‘residual’ and ‘institutional’ welfare states. These ‘models’ of social policy reflect very different theoretical perspectives on the causes of social inequality and the appropriate response of the state. The residual welfare state model is based on individualistic explanations of social problems and places responsibility firmly in the hands of individuals (and their families). The state only assumes responsibility when the family or the market fails; it thus limits its commitment to those marginal and ‘deserving’ groups who lack sufficient resources either to purchase welfare support from the commercial sector or draw on family support. Supporters of this type of system argue that collective provision stifles initiative because it demands high levels of taxation and encourages dependency – that is, reliance on welfare benefits and services undermining individual responsibility, initiative and self-help. The welfare state exists to provide a residual safety net to prevent people falling into abject poverty. State benefits, under such a scheme, are ‘targeted’ at the poorest sections of society, providing a low level of benefit (in order not to deter people from taking low-paid work). Services are provided on a selective, as opposed to universal, basis requiring extensive means testing of claimants.

The institutional/redistributive model, on the other hand, was the one favoured by Titmuss and Marshall. It provided a platform of universal services for the whole population, reflecting an institutionalized commitment to collectively financed and provided welfare. The objectives of this model were not restricted to preventing people falling below a certain basic modicum of welfare, but sought instead to promote social justice, modify patterns of social inequality and create solidarity.

Titmuss' approach has been developed in recent years, in comparative social policy research, as the basis for classifying and categorizing contemporary welfare states. The work of Esping-Anderson (1990) has been influential in this regard and has sought to develop a typology of ‘welfare regimes’ according to the ways in which different societies allocate social goods. He identified three ‘regime-types’ outlined in Table 1.1.
Table 1.1 Esping-Anderson’s three models of welfare regimes

<table>
<thead>
<tr>
<th>Regime type</th>
<th>Type of provision</th>
<th>Impact</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liberal</td>
<td>Social rights do not reflect work performance or citizenship but demonstrable need – providing generally meagre and means tested (selective) benefits</td>
<td>The welfare system reinforces existing inequalities through work-enforcing, stigmatizing benefits reserved for those unable to compete in the market</td>
<td>USA</td>
</tr>
<tr>
<td>Conservative</td>
<td>The state assumes responsibility over individual welfare by requiring employers and employees to provide compulsory social insurance cover with fairly generous entitlements</td>
<td>The distribution of social resources rewards occupational achievement via the welfare state</td>
<td>Germany</td>
</tr>
<tr>
<td>Social democratic</td>
<td>Generous systems of high-quality universal benefits for all citizens irrespective of prior earnings, contributions or performance</td>
<td>Achieves social citizenship (as defined by Marshall) by providing a broad equality of status for all citizens</td>
<td>Sweden</td>
</tr>
</tbody>
</table>

As with any system of classification, a level of generalization is required to illustrate key points and it would be unrealistic to expect any given country to fit exactly within Esping-Anderson’s typology. Britain provides a good example of a welfare system which contains elements of all three models (including a core of universal services alongside occupational and means tested benefits). This combined approach is clearly central to New Labour’s view of the welfare state and they advocate a concept of progressive universalism (Kemp 2005). This increasingly means moving from universal benefits to selective benefits and a safety net provision for those unable to provide for themselves and their families. Welfare has also become closely linked to work but also includes some universal provision – a good example being Child and Working Tax Credits that are paid to people earning under £58,175 (2006/7) a year but which provide more support to lower-income families. The approach of the New Labour government (elected in 1997) is discussed in more detail in the next chapter. There have also been criticisms of the three welfare regimes model, given the western democratic context in which it was developed, and suggestions that there should be a broader typology (Powell and Barrientos 2004). In addition, it has also been argued that the model overlooks key aspects of welfare such as the role of the voluntary sector, is gender blind and in fact may simply be illusory and of little relevance (Rodger 2003; Bambra 2004; Dahlberg 2005).
Criticisms of state welfare

While the institutional model claims moral support for collective social provision, on the grounds that this promotes social justice and equality, supporters of the residual model would contend that an ‘institutional model’ welfare system requires unacceptable levels of state intervention in the personal lives of citizens – reducing individual choice and requiring high levels of taxation. Although the existence of, for example, universal health care increases the quality of life of those without adequate means to purchase private care, the burden of taxation may restrict the ability of others who, if they were taxed less, could have exercised their right to purchase from the commercial sector – either by buying private health insurance or by paying for it directly – thus limiting choice and freedom.

Concerns about the impact of interventionist, universal welfare systems have also been raised in other quarters, by feminist and black academics and by the disabled persons movement. While the type of welfare system envisaged by Marshall would doubtless improve the quality of life of many people, the unquestioned benevolence of welfare and the association of welfare with the ‘good society’ fail to deal with important questions about institutional power and social control. Clearly, such large bureaucratic welfare organizations wield enormous power and may become the mechanism for controlling the lives of citizens as much as helping them. Education policy, for example, may be as much about reinforcing traditional class boundaries – by selecting, sorting and inculcating norms into the prospective workforce – as it is about the promotion of equal opportunity and merit. The caring professions are centrally concerned with welfare, providing care and helping individuals and groups to meet their needs. However, they are part of the ‘welfare system’ and are often in an ambiguous situation: they act on behalf of the state and tend to have a control function over individuals in terms of their structural position, at the same time as the conscious motivation of individual workers may be to help, support and work on behalf of their clients/patients. This ambiguity has been thoroughly explored in the case of social workers, and to some extent, with regard to health visitors and psychiatric nurses (Hugman 1991; Williamson 1992; Abbott and Meerabeau 1998), but it is equally true of all who work within the welfare system, in whatever capacity.

The role of the state as an instrument of social control, responsible for reinforcing existing patterns of social inequality, has been highlighted in the work of feminist social policy academics (Williams 1989; Pascall 1996; Lister 2003). Gillian Pascall (1996: 13) notes that: ‘Marshall asserts the rights of citizenship, but nowhere does he analyse the problematic relationship between citizenship and dependency in the family as he does between citizenship and social class’. In a similar vein, Lewis (1992: 161) argued that comparative work ‘misses one of the central issues in the structuring of welfare regimes: the problem of valuing the unpaid work that is done primarily by women in providing welfare, mainly within the family, and in securing those providers social entitlements’. On the basis of this analysis, she developed an alternative framework that stressed the broad commonality of women’s experience and the dominance of the male breadwinner family model, which cuts across
established typologies of welfare regimes. Although the strength of this model varies depending upon the extent and nature of social entitlement, Lewis (1992) emphasizes its persistence and universal impact:

Modern welfare regimes have all subscribed to some degree to the idea of a male breadwinner model – the strength or weakness of that model serves as an indicator of the way in which women have been treated in social security systems; of the level of social service provision particularly in regard to childcare; and of the nature of married women’s position in the labour market.

(Lewis 1992: 162)

Issues of welfare provision have been bound up with ideologically-motivated notions about gender relations which restrict women’s involvement in paid work (and their financial autonomy), effectively creating a vast army of unpaid workers upon whom the welfare state depends. As a result, many married women in the past, as now, had no independent social entitlement but instead gained access to social resources (such as income support and pensions) via their male bread-winning partners. The impact on women’s autonomy has been well documented (Lewis 1992, 2002; Ackers 1994) and continues to impact on the position of women today, particularly in relation to pension provision. In addition, inequalities between men and women, between those with and without disabilities and between different ethnic groups, have become institutionalized within state welfare systems in terms of income and the distribution of paid work, with much part-time, informal and non-professionalized care being undertaken by women and people from ethnic minorities (Carter 2003). The following section looks in a little more detail at the evolution of British social policy and the changing balance of social responsibility.

The development of the welfare mix in Britain

In Britain, the welfare state is seen as having moved from a residual (safety net) position to a more collectivist one, although in the last 25 years there has been some movement back towards a more pluralist position – with critiques developing on both the political Left and Right. The history of the post-war British welfare state is generally presented as the progressive development of social policies designed to stamp out want, poverty, ignorance and ill health – a move towards the gradual and progressive assumption, by the state, of responsibility for the welfare of all citizens. A civilized society is seen as one that cares and provides for all its members, especially the weak and vulnerable. Indeed, Titmuss (1968) argued that the collective provision of welfare encourages collective altruism – that is, a concern for the welfare of others. He used blood donation as an example, pointing out that in Britain, people are prepared to donate their blood without charge, thus ensuring a supply of good quality. The NHS has been presented as the pinnacle of the idea of state welfare – a free health service, provided equally to all, based on need and not the ability to pay.
Until the 1970s, there was a general consensus in Britain that the state should be the main provider of welfare services. The major concern then was about providing more services, about funding the growth of state welfare services. The concern now is whether the state should be the main provider or even the main funder of welfare services, and the extent to which the welfare state actually meets people’s welfare needs.

It became clear from the 1970s onwards that all sides in Britain were dissatisfied with aspects of the old system of welfare. The New Right (a term used to describe political ideology in the 1980s that espoused libertarian and conservative approaches to the role of the state – Baggott et al. 2005) denounced the profligacy of public services and the traditional Left questioned their paternalistic and bureaucratic character. Furthermore, it had become evident that welfare policies did not meet the needs of the British black and southern Asian populations and were often racist. Feminists have pointed out not only the patriarchal assumptions that informed much social policy, but also the ways in which state policies assumed the nuclear family with dependent wife as natural and inevitable. Changes in the social composition of the UK, demographic changes (such as an increasing older population), changes in family composition (such as the increasing number of single-parent families) and in employment patterns (particularly increasing women’s employment); created debates about the causes of the social problems to which welfare was directed and the proper role of the state in its provision.

One response has been to argue for ‘welfare provision which is universal in that it meets all people’s needs, but also diverse and not uniform [reflecting] people’s own changing definitions of difference and not simply the structural differentiation of the society at large’ (Williams 1989: 209). Initial responses from the Conservative governments of the 1980s and 1990s, were to argue for a reduction in the provision of state welfare, the more effective targeting of benefits and services and the reorganization and reduction of public services. In doing so, they reinforced the idea of the primary responsibility of individuals and their families – especially in caring for children and dependent relatives, whose care was seen primarily as a matter of private concern rather than as a collective responsibility.

Central to Conservative reforms in the 1980s and 1990s was the opening up of the supply of welfare services and making them subject to market-type forces. Three strategies were pursued, involving the introduction of internal or quasi-markets into public services such as health, education and social care; the use of private investment and provision in welfare (such as housing and pensions); and the development of public-private partnerships drawing private sector management into public sector provision directly and indirectly (Powell 1998). The role of the commercial and voluntary sectors was emphasized, especially in terms of competitive tendering for the provision of meals and laundry services in the NHS and in providing community care, as well as in the privatization of public utilities and other previously state-owned services. In reality, the Conservatives did not ‘roll back’ the welfare state, and indeed the percentage of gross domestic product (GNP) spent on state welfare remained remarkably constant. However, there were significant changes in the way in which the welfare state itself was organized and administered, which provided the
basis for a mixed approach to welfare provision, shifting the relationships between and roles of the public, private and voluntary sectors (Powell 1998).

When the New Labour government came to power in 1997, there was a further shift in approach which saw the retention of many features of previous government policy, including an emphasis on privatization and individual responsibility, combined with a commitment to tackling poverty and inequalities. A central theme was the link between welfare and work, with an emphasis on opportunity with responsibility (Deacon 2002; Lewis 2004). The Labour government promoted a new philosophy of the Third Way, treading a line between paternalistic, bureaucratic state control and the uncertainties of the market (Powell 2000). We can see how this approach dominates debates about welfare services today, with the emphasis on paid work, rights and responsibilities and the individual’s relationship with welfare services encompassed in debates about how pensions should be provided and proposals to increase choice in health care services. An important element of this new approach was to see welfare not as a burden but in terms of social investment: ‘In place of the welfare state we should put the social investment state, operating in the context of a positive welfare society’ (Giddens 1998: 117). A further, and an increasingly important element of New Labour’s approach to welfare is the idea of choice, which has cast the welfare user as consumer, choosing between different welfare services (Clarke 2004). Choice currently dominates the public services agenda and this, together with welfare pluralism and increasing privatization, impacts on the type of welfare state that exists in the UK. In health and social care, choice has become a dominant paradigm. In England, Our Health, Our Care, Our Say (DoH 2006) explicitly focuses on the role of the consumer as being responsible for managing their own health and choosing between different locations for treatment.

Social policy and social goods

This chapter has so far looked at the scope of social policy as a discipline. It has emphasized the need to consider the whole breadth of welfare provision within a mixed economy approach and the complex and changing nature of the state. A central aspect of this involves consideration of the welfare state in the provision and regulation of welfare. The concept of the welfare state itself has been shown to be highly sensitive, not only to economic expediends but also to ideological, moral and politically motivated pressures. The final point to be made here concerns the concept of a social resource itself. We have noted the concern of social policy with systems of social distribution, or how social goods are distributed in society and needs are met. But we have not yet defined which ‘goods’ or resources are ‘social’ as opposed to economic, political or simply luxury. Traditionally, concern has focused on resources such as health care, domiciliary care, social work, education, income support, housing, employment and education. Michael Cahill (1994), however, has suggested five additional ‘social goods’ that should be included within the study of social policy:
1. **Communicating**: telephone, fax, letters and e-mail.
2. **Viewing**: radio and television.
3. **Travelling**: rail, road and air transport.
4. **Shopping**: location and planning of shopping centres.
5. **Playing**: provision of leisure facilities, swimming pools, youth clubs etc.

Cahill goes on to point out that studying these areas is important, not only for understanding old and new inequalities, but also because policies are interdependent. This is illustrated in Chapter 5, with the prevention of obesity as an example. We cannot, he suggests, understand or evaluate policies in isolation:

> we can only provide good social policies if we are sensitive to the context in which government policy programmes operate . . . Adopting this perspective does mean that we must see social policy as part of a wider public policy. Health care is a good example, where governments now acknowledge that many other public policies have a health dimension. But the process should work the other way as well: transport policies are dependent on housing and retailing policies, retailing policies have health dimensions, and so on. One could produce a long list of these policy inter-dependencies.

(Cahill 1994: 2)

We might add to this list the issue of environmental policy, which is increasingly seen to fall within the parameters of social policy and which has important implications for health status (George and Wilding 1994). In fact, social policy now covers a very broad range of social programmes, with its increasing concern with social need and social inequalities, and divisions and areas of policy include criminal justice, equal opportunities, race and ethnicity, immigration and a concern with international dimensions, including European social policy, development issues and the role of international trade and finance together with its impact on welfare in the UK and other countries. For example, labour migration, as illustrated in Chapter 10, is highly relevant to the study of health in the UK, in terms of movements of skilled health care professionals in the European Union (EU) but also from developing countries, where inward migration to the UK has severe implications for staffing health care services in countries such as Ghana and South Africa. Increasingly, the language of social policy is developing around concepts such as inclusion and exclusion, social capital and inequality (Baldock et al. 2003). More importantly, much analysis of social policy examines the interrelationship of these concepts and what the role of the state is in addressing these, and what needs to be done to alleviate social exclusion and inequalities.

### Social policy: a contemporary analysis

The discussion in this chapter has identified different ways that social policy can be examined. Writing in the early 1980s, Alan Walker (1983) suggested social policy could be defined as:
The rationale underlying the development and use of social institutions and groups which affect the distribution of resources, status and power between different individuals and groups in society. Thus social policy is concerned both with the values and principles which govern the distribution as well as their outcome. The task of the social policy analyst is to evaluate the distribational impact of existing policies on social welfare, their implicit and explicit rationales, their impact on social relations and the implications of policy proposals.

(Walker 1983: 141)

Baldock et al. (2003: 7) suggest that social policy can be categorized into three broad areas:

1. The intentions and objectives that lie behind policies.
2. The administrative and financial arrangements that are used to deliver policies.
3. The outcomes of policies, particularly in terms of who gains and loses.

While the intentions or aims of policies are often clear, in many areas of social policy it is more difficult to identify what the intentions of a policy are. This is particularly true when the benefits or services have been accumulating over a number of years. In addition, intentions may be contradictory or not stated explicitly. Generally, the intentions of social policy can be grouped into three headings: redistribution, risk management and reducing social exclusion (see Box 1.2). Redistribution has always been a concern of social policy, but while addressing risk and tackling social exclusion may seem more recent concerns, in reality the development of public health services, universal education, pensions and social security have always been focused on supporting those at risk and promoting inclusion. In fact, a prime concern of many of those in favour of the post-war welfare state was the need to promote social solidarity. This goal has not been abandoned, but the language and how people think about society has changed, so that terms such as social inclusion and social capital are now used rather than solidarity. Thus, key social questions today include how different communities can be integrated – especially recent immigrants and asylum-seekers – concerns about access to employment, public services etc. and in particular, what the proper role of government is in ensuring these things happen vis-à-vis the responsibility of the individual.

As can be seen from the preceding discussion in this chapter, the study of the administrative and financial arrangements of social policy formed much of the first development of the subject. While initially focusing on the delivery of the welfare state, analysis became more complex with the understanding of the six forms of welfare referred to in Box 1.1. More recently social policy analysis has begun to focus on the processes of policy-making and implementation (Bochel and Bochel 2004; Lowe and Hudson 2004), the importance of understanding how policies are made and delivered and the role of government, the private sector and the enormous range of not-for-profit agencies and interest groups. This has also involved a renewed interest in the role of professionals and managers...
in service delivery and what relationship the individual, especially as recipient of services and benefits, has with the policy process (Taylor 2003).

**Box 1.2 Intentions of social policy**

**Redistribution**

Two forms of redistributive policy are generally pursued. Vertical redistribution moves from richer people to poorer people to address what may be considered unacceptable levels of income inequality. Horizontal (or lifetime) redistribution is where the state taxes people to provide services they might otherwise not pay for, such as education or pensions.

**Risk management**

While social policies have always been about addressing social need, it is argued that there are a much wider range of risks in society, such as pollution and the negative consequences of new technology. We now live in a risk society (Beck 1992) where individuals have little power to protect themselves, so this is the responsibility of the state.

**Reducing social exclusion**

There is some ambiguity about what social exclusion means – it is a contested concept. It has been argued that it is just another word for poverty but its meaning is broader than this and originates in France, where its use relates to the way some people are excluded from society by virtue of a lack of skills, education, poverty or disability. Therefore, policies are needed to re-include them in society. Social exclusion occurs when there are substantial inequalities and thus relates to issues of redistribution and risk.

An interest in policy outcomes has become increasingly important and the New Labour government has invested substantially in approaches to ensure that policies succeed. The debates of the 1970s and 1980s identified what was seen by many as the failure of the welfare state in terms of the continuing problems of poverty, homelessness and ill health (Townsend 1979). While this relates to both the content and process of policy, in terms of identifying why it fails, it is also clear that analysing the effect of policy is an important element of social policy analysis. We need to know whether particular policies have achieved their desired results. However, this still places a relatively narrow focus on specific policies and their implementation. More recently, social policy has included broader analyses of the relationship between the state and society, to include areas such as governance, leading Levin (1997: 26) to argue that social policy is primarily about ‘the coming into being of policies and measures, which is part of a wider phenomenon, the interaction of government and society. From this standpoint, the definitions and boundaries which academics seek to assign to “social policy” are irrelevant as well as arbitrary’. 
Conclusion

The scope of social policy is thus very broad. While it is true that health policy forms one area of social policy, it is also clear that an understanding of the wider aspects of social policy is important to understand its development and to provide a clearer understanding of how people's lives are shaped by social problems. An understanding of health inequalities requires a broader understanding of wider social inequalities in society and a recognition of the way that health impacts on wider social issues is necessary to understand the full impacts of ill health. Similarly, the impact of social contexts on people's health is also a key component of understanding health and disease. Health and social care practitioners need to recognize that individual patients must be seen within their social context (family situation, socio-economic status, ethnicity, whether homeless etc.). The NHS itself is the construct of social policy and the way health care practitioners or social workers practice is the result of social processes.

The remainder of the book explores many of the issues raised here in more depth, mainly adopting a 'case study' approach. Chapter 2 examines the evolution of the welfare state, using health as an example, as it is only through an understanding of how the welfare state evolved that we can come to understand where it is today. Chapter 3 examines in more detail the changing context of health policy in the post-war period, demonstrating how health care has responded to changes in society and advances in health services. Chapter 4 examines the extent to which welfare services have met one of the major objectives of the founders of the welfare state: a reduction in poverty and inequalities. It also examines the nature of inequalities in relation to social division and how inequality and poverty relate to social exclusion. Chapter 5 builds on this discussion and examines the nature of health inequalities in the UK, and how the government has responded to them. In Chapter 6, we consider the pluralization of welfare services. In particular we explore the way in which private sector management practises and market forces have been introduced into the public sector, and the privatization of welfare, using health services and pensions as examples. Chapter 7 develops the discussion in Chapter 6, focusing on the increasing fragmentation and diversification of the delivery of public services. In Chapter 8, we focus on the increasingly important role of the voluntary sector in the provision of community and health care services. Chapter 9 then explores the development of lay involvement in health through the growth of the user movement. It also examines the role of carers and the importance of informal care in health and social care. Chapter 10 examines the occupational histories of different health professions, in particular nursing, medicine and social work. It discusses professional regulation and professional education and development. Each of these latter chapters considers how the boundaries between sectors, professionals and lay people, have been progressively blurred in recent years as a result of welfare retrenchment, more pluralistic provision and having to address more complex problems. The final chapter draws out themes arising from the previous chapters to highlight the growing importance and impact of globalization, workforce issues, public health,
changing patterns of service use and provision and new technologies. The chapter also examines how current issues such as health inequalities, the role of the state and social policy will remain central to future debates about health and health care. It asks whether the new balance of responsibility, within the mixed economy of welfare, has met the criticisms of the post-war welfare state and considers the implications of the new forms of partnership for social equality and citizenship.

Summary

- The study of social policy has evolved from a narrow concern, with the development and evaluation of state welfare, to a broader concern with the whole basis of social entitlement and social responsibility.
- The concept of welfare pluralism is used to describe welfare systems in which social needs are met through a wide range of sources including the voluntary, commercial, informal and state sectors.
- These sectors do not operate independently of each other but rather interact in a complex manner with other welfare providers and with other aspects of public policy (e.g. on the economy and environment).
- While a mixed economy of provision characterizes the whole history of social policy in the UK, political ideology has an important impact on the balance between the main providers of welfare.
- The influence of ideology is illustrated through the concept of welfare models (the residual and institutional models) and subsequent welfare regimes.
- Central concerns of social policy now address the problems of diversity and difference, and how these interact with inequalities.

Further reading