

Key Concepts in Social Policy

This assignment will examine what social policy is, how policies are created and what drives the policy process. The essay will look at historical context, political influence, important landmarks in policy creation and key issues that prompt policy reformation. It will take into account social demographics and the effects of policies and legislation on a specific social sector. The area of policy this assignment will focus on is the elderly, identifying what constitutes 'elderly' and some of the challenges that face an ageing population.

There is much debate surrounding the age at which person is considered elderly and in modern times the use of the terms early and late elderly have been introduced, perhaps adding to the ambiguity. The symptoms and conditions that are often associated with ageing can affect people at vastly different stages of life, depending on activity, lifestyle and genetics but it is generally accepted in medical practice that the chronological age of 65 is considered elderly, that being the age at which a person is treated as geriatric (Pickard, 2014). Retirement age was often considered a milestone. Until 2011, the compulsory retirement age for both men and women was 65. As a result of ardent campaigning though, that policy was finally abolished (Age UK, 2018).

What is policy though? A policy may be described as an idea, a statement of intent or perhaps a strategy for dealing with specific issues. In terms of social policy, Spicker (2014, pp.3-7) suggests it relates specifically to social services, policies designed to ensure individuals' basic needs are met, whilst reducing inequalities and promoting inclusion. Tackling issues such as health, education, employment opportunities, housing and welfare. The use of the term 'welfare' is open to interpretation and for example in the United States it is generally used to describe the benefits system. In its broadest sense though, Spicker (2014) puts forward the notion that it could be regarded generally as 'well-being' in so much as the intention is to promote positive outcomes for groups and/or individuals and reduce inequality.

For a policy to address issues of equality, debilitating circumstances are considered such as mental health, age, employment status and disability. Other parameters such as geography, gender, culture, race, religion, economics and environmental issues are also taken into account. For a policy to be effective, the potential impact on all parties or 'stakeholders' must be evaluated, along with the consideration of logistical implementation (Spicker, 2014).

The policy making process can be complex and the creation of one policy can often have unintended repercussions on another. The agenda for creating a policy can often change. It may evolve or even be hidden (Bochel and Bochel, 2004, p.26). To facilitate the process, theoretical models may be used to analyse and identify problems. There are many different models employed such as the 'Public administration model'. This worked on the idea that politicians would be responsible for creating policies under the guidance and scrutiny of impartial civil bureaucrats. This process was used widely up until the 1970s until the neutrality of the bureaucrats was frequently called into question.

A report published by the Institute for Government (Hallsworth, Parker and Rutter, 2011) formed part of a trio of documents commissioned to evaluate government policy process and highlight successful strategies. It recognised the importance of measuring the impact of a policy as opposed to merely giving weight to intention. The report also acknowledged the difficulty in monitoring success and cited the use of the ROAMEF policy cycle (HM Treasury, 2018) as a preferred process evaluation model.

The purpose of the ROAMEF cycle (Roamef.com, 2018) is to provide a link between public policy making and private sector implementation. The cycle comprises of six clearly defined stages, the components of which are explained below and illustrated in the graphic (Fig.1).

Rationale – The first phase is the consultation stage. Problems and issues are discussed, opportunities and barriers may be identified and feedback is provided by pressure groups and stakeholders.

Objectives – The main aims are outlined as short-term, mid-term and long-term objectives and carefully considered in terms of feasibility. A range of scenarios is contemplated with scope for the possibility of fluctuating parameters.

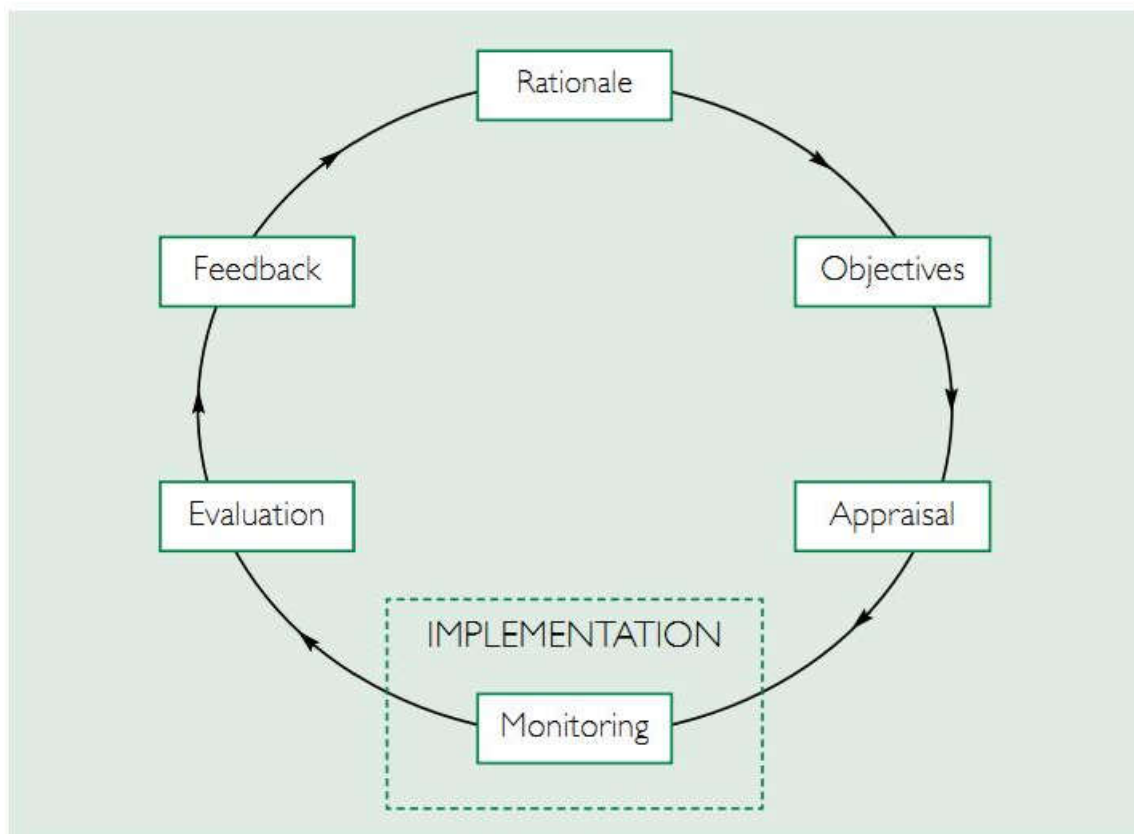
Appraisals – Options are appraised in respect of cost and value. Strengths and weaknesses are identified and balanced against any perceived risks.

Monitoring – Progress of objectives are observed once a suitable baseline has been established for the purpose data collection. Once this is in place, implementation can proceed and data can be qualified in order to measure whether the activities are achieving the desired result.

Evaluation – Early data indications give an insight into the effectiveness of the strategies employed and provide an opportunity to modify any areas of the policy deemed ineffective.

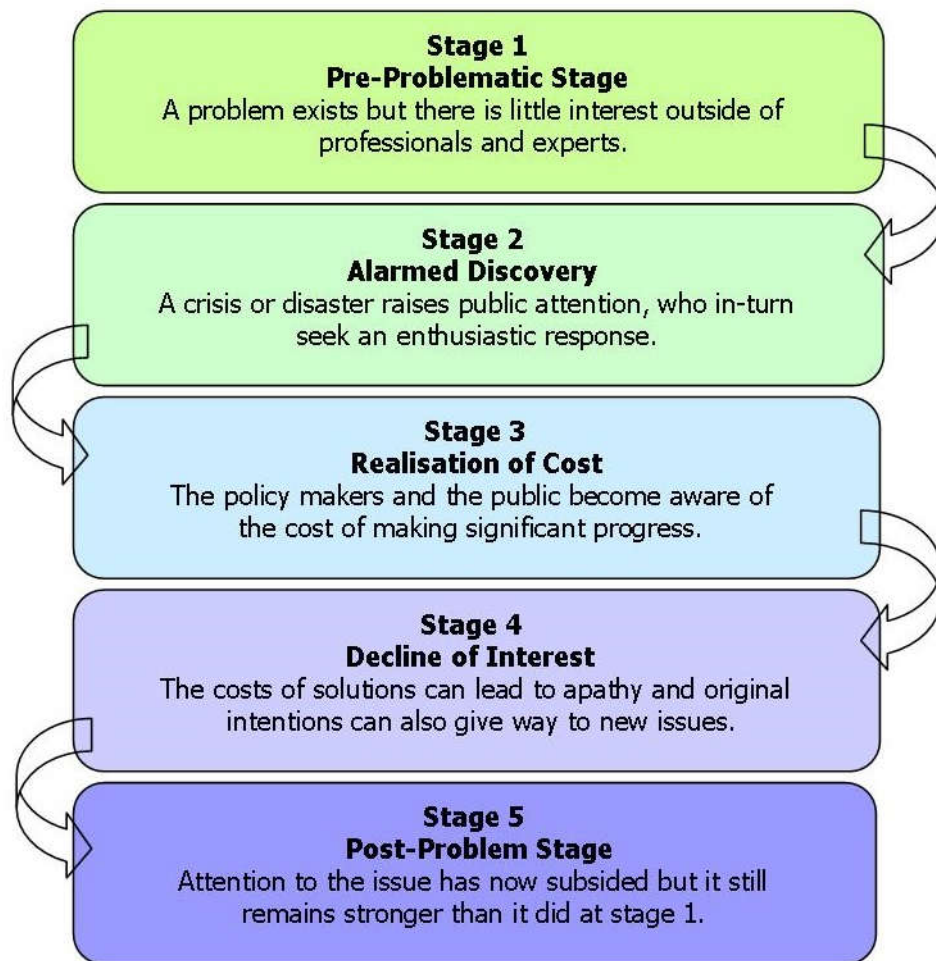
Feedback – The final stage of the cycle looks at what aspects of the policy works, for whom do they work, why do they work and what elements, if any, were less effective. Results can then be fed back to the original rationale.

Fig.1 – **ROAMEF Policy Cycle** (Roamef.com, 2018).



The creation, implementation and reform of health and social care policies are largely driven by the ideals and manifestos of whichever political party holds power (Bochel and Bochel, 2004, p.28). This can lead to certain issues being kept ‘off the table’ if they do not sit comfortably within a party’s ideology or agenda. Although policies are discussed regularly at government level, there is quite often a great deal of apathy from the public in general until a crisis, major event or an historical turning point raises public awareness. Interest can also subside as the cost of implementing policies becomes apparent and as new issues and policies arise. This can be seen in Downs’ (1972) ‘Issue-attention cycle’, as illustrated below (Fig.2).

Fig.2 – Issue-Attention Cycle



In the early post-war period following World War II, one such pivotal moment came in the form of a report. The Social Insurance and Allied Services (Beveridge, 1942) report was commissioned during wartime and marked a radical re-think in terms of the key issues affecting social care. The groundbreaking document identified what the author described as the ‘Five Evils’ of want, idleness, squalor, disease and ignorance. Following the report’s publication, there was an urgency to begin addressing these issues and social policy was at the forefront of political manifestos at the time.

A General Election in 1945 saw the two leading political parties both eager to grasp the opportunity to implement the ideas and ethos that Beveridge had outlined in his revolutionary paper, although parties to the left and right had differing ideas on how much social protection

should be provided by the government, as opposed to the free market economy. The consensus was there should be a universal safety net ensuring all citizens would be provided for (Alcock and May, 2014, pp.230-231).

In a shock result, it was the socialist Labour Party that emerged victorious in that election. Aided in no small part by largely Labour-backed military support, voters were keen to put an end to the economical austerity that wartime hardship had forced them to endure. The early euphoria of that victory was dampened somewhat by the difficulty of funding such an ambitious project and fierce opposition from the medical community made for laborious progress. Eventually, after two years of bitter negotiations a deal was reached and the Welfare State was born (Brown, 2001).

The elderly in many ways were perhaps early beneficiaries of the new welfare system, enjoying the benefits of medical treatment, free at the point use, without having made a lifetime of contributions, at least in financial terms. It could also be suggested that care of the older generations was one of the key areas where before long, social policy would require radical overhauls once more.

Throughout the 1950s and there were major shifts in attitudes towards social care. The large geriatric hospitals began to give way to smaller residential homes and a significant development came as part of the Mental Health Act (Department of Health, 1959) with the introduction of community care. As trends continued away from large institutions right throughout the 1960s and 70s, the issue of funding became perhaps one of the biggest factors in the need for reform.

The election of a Conservative government in the late 1970s, lead by Margaret Thatcher, brought with it the advent of Neo-Liberalistic ideologies. The focus shifted away from the idea of state provision in favour of the idea that 'well-being' could be best achieved through the freedoms and opportunities of entrepreneurship and a free market economy that would open the door for privatisation (Harvey, 2010).

During that Conservative reign, the Secretary of State commissioned a report (Griffiths, 1988) specifically aimed at streamlining the appropriated of public funding for community care. It was this report, along with the 'Caring for People' (Department of Health, 1989) white paper, in the following year would lead to the first radical overhaul of the National Health Service (NHS) since its inception (BBC News, 1999). Griffiths' review highlighted a

number of concerns, especially the gross financial incentives for families to seek residential care for relatives. The universal availability of benefits without the deterrent of means testing appeared to directly contradict the ethos of community care (The King's Fund, 2017).

The National Health and Community Care Act (Department of Health, 1990) that followed saw the privatisation of services being introduced to the NHS, the formation of regional NHS Trusts and the launch of a duty of care which made local authorities responsible for assessing the needs of vulnerable adults in respect of community care prior to arrangement. There was an exception for urgent cases that could be assessed retrospectively (The Health Foundation, 2018).

A key issue regarding budgeting for care of elderly appears to be the substantial increase in life expectancy. When the NHS was introduced in 1948, life expectancy was just 66 for men and 71 for women. By 2008 the figure for men had risen to 77.2 and 81.5 for women, respectively (McSmith, 2008). Ageism as a form of discrimination is becoming increasingly commonplace and in contrast to other forms of prejudice such as racism, is a phenomenon that obviously develops with age rather than something that could possibly be endured from birth (Rowe and Mitchell, 2013, p.22).

It is worth noting that since austerity was re-introduced to tackle the national deficit by the Conservative and Liberal Democrat coalition government of 2010, life expectancy has begun to slow. In fact figures published by the ONS (Office of National Statistics) in 2017, show that for the first time in over a hundred years that life expectancy in England and Wales has actually stalled (Dorling and Geitel-Basten, 2017).

Despite stagnation in the United Kingdom, the global trend of increased life expectancy will inevitably have repercussions for an ageing workforce. The employability opportunities could arguably be greater for older people not wishing to retire but there could also be adverse effects socially. Younger relatives, who may have once relied on parents and grandparents to assist with childcare responsibilities, may be forced to seek more formal care arrangements to meet their own working expectations. Figures forecast across Europe indicate that by the year 2050 some countries expect the number of retired adults to be almost equitable to the number of people in work (Broughan, 2012).

In conclusion, the fundamental principles of social policy creation, the models and theories behind the process and the desired outcomes in terms of 'well-being' have changed very little

since the birth of the modern welfare state. Where social policy has most notably evolved appears to be in the way 'well-being' is perceived and measured and also in the strategies employed to deliver policies effectively. The demographics within society have also changed and continue to do so. The population has not only increased in terms of longevity in the past 70 years but has also increased significantly in size. As recent as 1960 the UK population was estimated at approximately 52.3 million compared to a figure of around 65.6 in 2016 (Office of National Statistics, 2017). Regardless whether life expectancy increases or continues to stall, the key factor in dealing with what is increasingly becoming a crisis in care would appear to be maximising efforts in sustainability.

Moving forward, legislation from the Welsh Government in the form of the Well-Being of Future Generations Act is paving the way for a more cohesive approach in the delivery of services. The act requires public bodies to work together responsibly, taking into consideration all aspects for potential impact, both positive and negative that may arise from future policies in areas such as the environment, economy, culture and equality. The vision is ambitious, yet comprehensive and has drawn interest globally at a time when long-term planning is at the forefront of social policy (The Future Generations Commissioner for Wales, 2018).

Only time may tell if true sustainability can be achieved but proactive prevention must surely provide the greatest opportunity for long-term solutions. Resources and funding appear to be ever decreasing but the objectives remain. Whatever the approach, the original ethos of the welfare state should not be forgotten.

There is little likelihood, therefore, that Britain will, in the foreseeable future, take the advice of those who wish to move towards the American model by charging patients as much as they can afford to pay for all services, and leaving them to cover the cost, as far as they can by voluntary insurance. To do so would be to violate the basic principles of the National Health Service as conceived by Aneurin Bevan, namely that no element of commercialism should enter between doctor and patient, and that illness is neither an indulgence for which people ought to pay nor an offence for which they should be penalized, but a misfortune the cost of which should be shared by the community (Marshall, 1967, p.146).

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