

THIS UNIT IS ABOUT SOCIAL ISSUES AND WELFARE NEEDS. It will help you to develop your knowledge and understanding of the perceived social issues and welfare needs in our society. Some of these issues have been with us since records began – and probably before that. Others are new areas of concern and, arguably, a product of more recent social and economic changes. This unit will provide you with the background knowledge that you will need to complete Unit 11 of the Edexcel GCE Health and Social Care award. You will learn about:

- The origins of issues that are of social concern.
- How changes in the size and structure of the population can present new issues and influence welfare provision.
- How social and welfare issues are linked with the political, social and economic circumstances of the society.
- How governments have responded to the identified areas of welfare need.

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Unit 11

Social Issues and Welfare Needs



Key questions

By the end of this unit you will be able to use the knowledge and understanding that you develop to answer the following questions:

- 1 How are social issues linked with the wider social and political culture of the society?
- 2 How do changes in the population affect the welfare needs of the society?
- 3 What are the perceived key issues and welfare needs that exist in our society?
- 4 How have government and other influential groups responded to identified welfare social needs?

Topic 1

Social factors and areas of welfare need

Getting you thinking

- 1 Should the family look after frail older relatives, or should the state provide residential care?
- 2 Should people put money aside for a 'rainy day' – periods of ill health or unemployment, for example – or should the state help?
- 3 Should the state help only the poor – and others should pay for their care?
- 4 Do social security benefits lead to people becoming scroungers?



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Unit 11 Social Issues and Welfare Needs

KEY TERMS

Dependency culture

The view that a welfare state will create a society where people rely on state benefits and services rather than working, planning for the future and taking responsibility for their own lives.

Industrialisation

The move towards basing an economy on the production of goods in factories, mills and mines rather than on agriculture and other cottage industries.

Laissez-faire

A view that the government should not interfere in the workings of the economy or in the provision of welfare services. The government should 'leave well alone'.

Post-industrial society

A society whose economy is no longer dependent on the production of goods but is now based on services and office-based occupations.

The New Right

A political viewpoint committed to minimal state provision of welfare services. Taxes should be low and people should decide how they spend their money – making their own provision for health and welfare needs.

The Third Way

An approach to welfare that tries to combine individual freedom and responsibility with state provision for those most in need.

Urban living

Living and working in towns and cities, rather than living and working off the land in agricultural communities.

Welfare state

A term, first used during the 1940s, referring to a system in which government took a primary responsibility for the health and welfare of the nation through the provision or monitoring of services. The services, developed following the Second World War, included the National Health Service, Family Allowance, secondary education for all, and social security benefits and pensions.

Who cares for the vulnerable?

In all societies there are groups of people who are potentially vulnerable. These include children, older people, people with disabilities and the poor, for example. Whether they are supported and how they are supported, however, varies from society to society and at different times in history.

In some societies, the care of the vulnerable is seen as the responsibility of the family or the village. In others, it is principally the responsibility of the state, through community provision. In Israeli kibbutzim, for example, the care of children is seen as the responsibility of the whole community, and not principally the concern of the birth parents. In other societies the care of children is the prime responsibility of their parents, and in some it is the responsibility of the extended family. Attitudes to the vulnerable vary. Those on benefits may be seen as 'lazy scroungers', or their situation may be seen as the result of poor parenting or the inevitable consequence of economic changes. The response to their need will vary according to the dominant attitudes in the society, the views and priorities of government, the wealth of the nation, and how that wealth is distributed and managed.

The state, the church and the family

In England, the state has had some involvement in providing for the poor since Elizabethan times. The 1601 Poor Law allowed officials to collect money from each household in their parish and to distribute it to the needy. There were two kinds of poor law relief – 'outdoor relief' and 'indoor relief'. Outdoor relief was the financial help given to people who were living in their homes but regarded as destitute. In order to receive indoor relief people had to live in an institution, normally called the workhouse. State support, however, was minimal, and personal care was considered to be largely the responsibility of the individual and their family. The poor, it was thought, had only themselves to blame. If people worked hard, saved for 'rainy days' and understood the value of family life they would not be needing relief. Depending on 'poor law relief' was seen as shameful and unnecessary.

The political approach at the time – **laissez faire** – was informed by a view that the government should not interfere in the workings of the economy or in the provision of welfare services. The church and other voluntary groups provided charitable support, but the

state 'left well alone'. Not until the opening years of the twentieth century did the state begin to take a proactive role in the care and welfare of its citizens.

The Liberal reforms

The growth of **industrialisation, urban living** and the associated poverty, homelessness, ill-health and high mortality rates led social reformers and politicians to the view that the state would have to play a bigger role in the provision of welfare services. The Poor Law provisions were not meeting the needs of the individual or the economy. Employers needed a healthy, educated and reliable workforce. The Liberal government of the early twentieth century played a key role in increasing state involvement in personal health and care services and, some would argue, laid the foundations of the **welfare state** (see below). There was a gradual move away from the laissez-faire economic liberalism of earlier years to a more supportive welfarism by government.

Welfare reforms introduced by the Liberal government (1905–1915)

1906

- The Education (Provision of School Meals) Act
- Providing school dinners for poor children

1907

- The Old Age Pensions Act
- The Labour Exchange Act
- School medical inspections
- The introduction of juvenile courts

1911

- The National Insurance Act

Figure 1 Reasons for state intervention



Caring for older people

Mrs Brothers is 85 years old and lives quite independently in a small and comfortable flat in the north of England. She has three adult children, one in Australia and the others, both married who live in London. Her GP's surgery is nearby. She has meals-on-wheels delivered three days a week and a home care assistant visits her once a week to help with household chores. This is very different from her childhood memories. Her grandparents lived in the countryside. There were no pensions, they had to pay to see the doctor, they had to find the rent for their house and there was certainly no meals-on-wheels. While her grandfather was working they had managed to pay their bills. They had saved a bit of money too but this money ran out and in the end they were forced to go and live in the workhouse to survive.

The birth of the 'welfare state'

The 1940s saw the development of legislation that reflected an agreement across the main political parties that the state should take an increased responsibility for the funding and provision of welfare services. The specific measures taken were based on the proposals of Sir William Beveridge (1879–1963) and published in his *Report on Social Insurance and Allied Services* (1942), more commonly known as the Beveridge Report. Beveridge based his recommendations on his concern to defeat five 'giant evils' that, despite the measures of the early twentieth century, were still hindering social and economic progress in Britain. The five evils identified were:

- Want (poverty)
- Disease (ill-health and high mortality rates)
- Ignorance (inadequate education)
- Squalor (poor housing and homelessness)
- Idleness (unemployment).

The existence of poverty in Britain was the underlying reason for commissioning the report, but legislation was passed and services introduced that addressed each of the 'five giants'. These measures, together, represented a radical approach to welfare services, building on the initiatives of the Liberals at the turn of the century but representing an agreement that the state had a central role in ensuring basic standards of care and support for all.

The development of what came to be known as the 'welfare state' was a sea change in the approach to welfare. There was a new focus on the role of government, government policy and state intervention in welfare. A brief consideration of the key services – which largely remained in place until the 1970s, and some we would still recognise today – provides a clear picture of how the new system would provide care and support 'from the cradle to the grave'.

Want (poverty)

- Family Allowance Act 1945 introduced a financial payment for children under 15. This did not apply for the first child but applied for all subsequent children.
- The National Insurance Act 1946 allowed for the payment of unemployment benefit, sickness benefit and retirement pension, maternity benefit and widow's pension for all who, when in work, paid weekly from their wages into the national insurance scheme.
- The National Assistance Act 1948 provided a 'safety net' – a minimum income for people who did not pay into the national insurance scheme and were, therefore, not eligible for those benefits.

Disease (ill-health and early mortality)

- The National Health Service Act 1948. Before the introduction of the National Health Service (NHS), if people needed to see a doctor or have hospital treatment they normally had to pay. A national service was central to the post-war welfare reforms and was based on three principles:
 1. That health services should be free to all at the point of delivery (when they are actually used).
 2. That the service would be truly national, covering the whole population in all parts of the country.
 3. That access to services would be based on clinical need (not on the ability to pay).

Idleness (unemployment)

In the post-war period, rather than 'letting well alone' the government intervened in the running of the economy, using the approach of John Maynard Keynes (1883–1946) to support a policy of full employment, which was recommended and necessary for the success of the Beveridge reforms. It was through full employment that his reforms would be financed.

Ignorance (inadequate opportunities for education)

- The 1944 Education Act provided free secondary education for all. Up until this change, most young people in secondary schools paid for their education. Only a minority had free scholarship places. The school leaving age was raised to 15, and grants were made available for people studying at university.

Squalor (poor housing and homelessness)

- The New Towns Act 1946 provided for new towns to be built or developed to address housing shortages, e.g. Stevenage, Welwyn Garden City and Cumbernauld.
- The Town and Country Planning Act 1947 required local authorities to agree building plans for their local area that would benefit the community as a whole.

Welfare and the 'New Right'

The services which arose after the Second World War established a framework for provision and a range of services that remained in place for the generation that followed – and many are still in place today. These were not significantly challenged until the Conservative victory at the 1979 election. The view of this government – led by the first woman prime minister, Margaret Thatcher – was, once again, that the government should interfere as little as possible in the running of the economy and the provision of welfare. The view of her government was that care and welfare should be the responsibility of individuals,

their families or charities. The welfare state, it was argued, supported a **dependency culture**. The **'New Right'** was concerned to see a 'rolling back' of the welfare state.

The 'Third Way'

The Third Way is an approach to welfare associated with 'New Labour' and the Blair governments. Its aim is to steer a line – some would say shape a compromise – between the welfare state's full involvement of government in welfare and the **New Right's** reluctance to intervene in welfare at all. The proponents of the Third Way aim to foster personal and family responsibility for welfare and the quality of community life but, at the same time, provide support to avoid the extremes of deprivation. They are trying to develop a spirit of community in which people accept responsibility for themselves but also for the most vulnerable in society. People would therefore be maintaining a balance between their individual freedom and their responsibilities towards society as a whole.

Check your understanding

- 1 What is meant by the term 'laissez faire'?
- 2 What is meant by the term 'welfare state'?
- 3 What were the five 'giant evils' addressed in the Beveridge Report?
- 4 Why may a welfare state produce a dependency culture?
- 5 Briefly describe the approach of the new right.

extension activities

- 1 Using the local library, find out if there was a workhouse in the area where you live. When did it close? What provision was then made for the vulnerable elderly who were not able to live in the community?
- 2 What provision is in place in your area now for the vulnerable elderly? Would you say that it reflected the provision of a welfare state, the new right or the third way?

Topic 2

Demographic change and welfare need

Getting you thinking

Think about all the television adverts that portray 'families'.

- 1 How is the family typically portrayed in these adverts?
- 2 Do you think this is a typical family in modern Britain? Give reasons for your answer.
- 3 Are there often older people in these adverts? If not, why not?
- 4 Why might people chose to leave their homes and live in another country?



KEY TERMS

Birth rate

The number of live births per thousand of the population in one year.

Death rate

The number of deaths per thousand of the population in one year.

Infant mortality rate

The number of deaths of infants under one year of age, per thousand live births.

Immigration

People coming to live in a country from another country.

Emigration

People leaving a country to live in another country.

Net migration

The difference between the number of immigrants and the number of emigrants coming to and from a specific country.

Life expectancy

A statistical measure which predicts the average number of years a person is likely to live. This could be estimated from any particular age, but is usually expressed as from birth.

Dependent population

The age groups who are dependent on the rest of the population for economic security – young people from 0–16 years, and people over the retirement age.

Population trends and demographic data

Demography is the term used to describe the study of the size and structure of the population. Demographic statistics are used by governments, planners and social scientists to identify changes in population. Some of the things that governments may need to know include:

- the trends in **birth rate** – to inform provision for children and young families
- the trends in **life expectancy** – to inform provision for older people
- levels of unemployment
- regional differences in the size and structure of the populations
- levels of migration, both within countries and between countries.

The census

Every ten years since 1801, with the exception of 1941, there has been a census – a detailed count of the population. The last census was in 2001, and the next is planned for 2011. At the census, every householder is required by law to provide details of everyone staying in their household on the designated night. Included in the census are people in hospitals, hotels, prisons and all other institutions. In addition, there is every attempt to record the number of people who are homeless or in temporary accommodation. This information is used to inform central and local government planning. It is also used by many other independent organisations to help manage their work and target their resources.

The population of the United Kingdom – England, Wales, Scotland and Northern Ireland – on census night 2001 was 58,789,194, of which almost 50 million lived in England. The census website provides detailed information on the census findings. Information includes the following detailed statistical information:

- 11.7 million dependent children (0–16) lived in the UK.
- 22.9% of dependent children lived in lone-parent families.
- 17.6% of children lived in ‘workless’ households – that is, where there are no adults in work.

- 21% of the population were over 60 years of age.
- 20% of the population were under 16 years of age.
- There had been a big increase in the number of people over 85 years of age – now over 1.1million, or 1.9% of the population.

There is information relating to family size and household structure, levels of education and employment, race and ethnicity, religious adherence, and the quality and sufficiency of housing. The 2011 Census Programme is already in place, preparing for the next census. There are proposed measures to employ staff to follow up areas of low-response rates and, for the first time, to introduce internet response facilities.

The Office of National Statistics

The Office of National Statistics (ONS) is the government department that provides ongoing demographic, economic and other social statistics used by government and other policy-makers to inform planning decisions and to monitor progress. Data published includes the registration of all births, deaths and marriages, and regular publications, including *Social Trends* and *Population Trends*, available in hard copy and electronically.

Voluntary organisations and other independent sources of research

Many charitable organisations will systematically collect data in order to plan and monitor their activities, present information to their funders and to educate and provide statistical evidence to support their causes. Pressure groups and specific-interest groups will present research data to support their cause. Academic researchers will also contribute to the body of knowledge on a wide range of health and care issues. Throughout this textbook you will find evidence drawn from these sources.

When using statistical information it is, of course, essential to record the *source* of data and also to consider the authors’ *purpose* when they supplied the data. If the data is supplied by a pressure group, is it presented in such a way that it will be persuasive? If the data is from a newspaper, is it aimed at the particular views and prejudices of its readers? Has there been important data omitted? Do you need to look further for fuller information? Should you consult data from an organisation known to support a different point of view on this issue? Statistics must always be used with caution, and presented with care.

Natural changes in the population

Natural changes in the population include changes in the birth rate and the **death rate**. The birth rate refers to the number of live births per thousand of the population in a given year and the death rate to the number of deaths per thousand of the population in a given year. The presentation of the statistics in this form allows for meaningful comparisons of natural changes in the population over periods of time, and from one country to another.

Changes in the birth rate

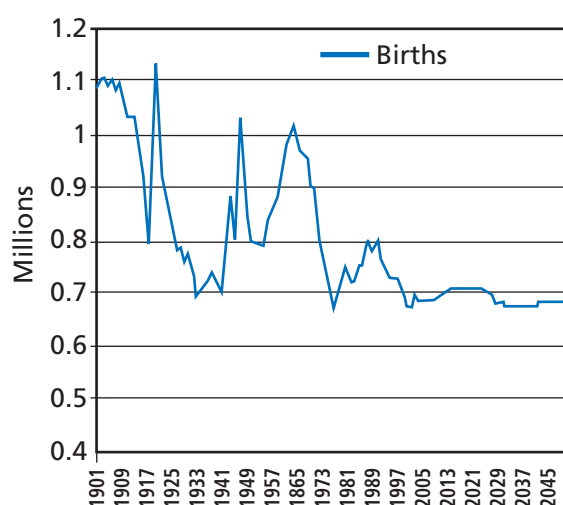


Figure 2

Source: Office for National Statistics

It would be difficult to give precise reasons for the changes in the birth rate in the last hundred years, but it would be reasonable to assume that the factors involved include:

- Improved methods of contraception
- The greater availability of contraceptives
- Women choosing work and a career over large families
- The high cost of child-rearing.

The birth rate across Europe is at its lowest since the Second World War, and is continuing to fall. The Spring 2005 edition of *Population Trends* reported that birth rates in the UK are currently below the level needed to replace the population – which could lead eventually to a fall in population. This fall, however, will most likely be delayed by other factors – such as the falling death rate and inward migration.

Changes in the death rate

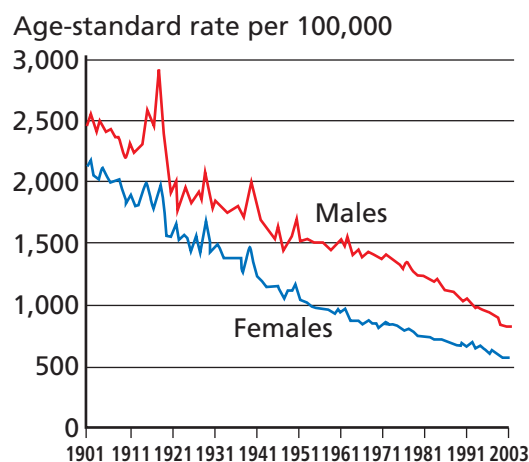


Figure 3

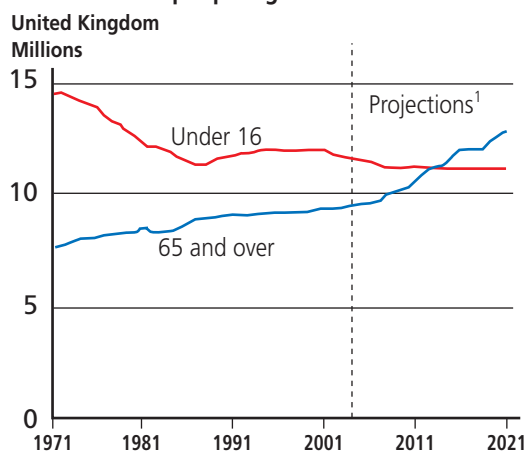
Source: Office for National Statistics

The fall in the death rate, of course, is another way of expressing the fact that people are living longer – there has been an increase in **life expectancy**. The fall in the death rate may be directly attributed to such factors as:

- Improved sanitation
- Effective immunisation programmes
- Discovery of penicillin
- Advances in medical knowledge
- The introduction of the National Health Service
- Improved living conditions and housing
- Improved standards of living.

The fall in the death rate is leading to an ageing population. The implications for social care providers will be discussed in the next topic.

Under 16s and people aged 65 and over



¹ 2003-based projections for 2004 to 2021.

Figure 4

Source: Office for National Statistics

Improved infant mortality rates

Figure 5 Life expectancy and healthy life expectancy at birth: by sex

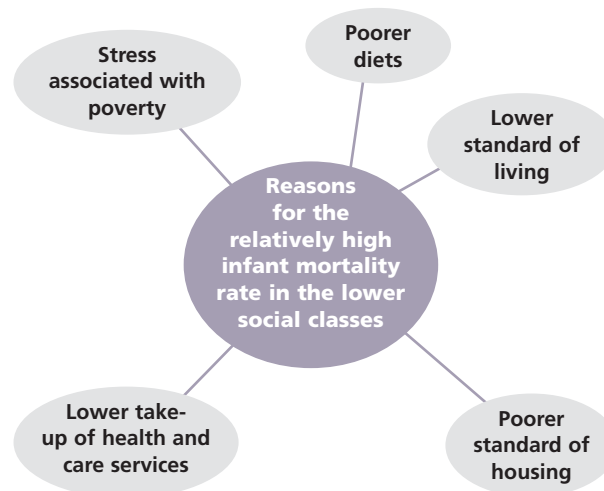
Year	Live births per 1,000 population	Infant deaths per 1,000 live births	Crude death rate	Childhood mortality (per 1,000 population aged 1 to 14)
1948	18.1	36.0	10.9	1.8
1949	17.0	34.1	11.7	1.6
1950	16.2	31.2	11.7	1.4
1951	15.8	31.1	12.5	1.4
1952	15.7	28.8	11.4	1.2
1953	15.9	27.6	11.4	1.2
1954	15.6	26.4	11.3	1.0
1955	15.4	25.8	11.6	1.0
1956	16.0	24.4	11.6	0.9
1957	16.5	24.0	11.5	1.0
1958	16.8	23.3	11.7	0.9
1959	16.9	23.1	11.7	0.9
1960	17.5	22.5	11.5	0.9
1961	17.9	22.1	11.9	1.0
1962	18.3	22.4	11.9	0.9
1963	18.5	21.8	12.2	0.9
1964	18.8	20.5	11.3	0.8
1965	18.4	19.6	11.6	0.8
1966	18.0	19.6	11.8	0.9
1967	17.6	18.8	11.3	0.8
1968	17.2	18.7	11.9	0.8
1969	16.7	18.6	12.0	0.8
1970	16.3	18.5	11.8	0.7
1971	16.2	17.9	11.5	0.7
1972	14.9	17.5	12.0	0.8
1973	13.9	17.2	11.9	0.7
1974	13.2	16.8	12.0	0.7
1975	12.5	16.0	11.9	0.6
1976	12.1	14.5	12.1	0.6
1977	11.8	14.1	11.8	0.6
1978	12.3	13.3	11.9	0.6
1979	13.1	12.9	12.0	0.5
1980	13.4	12.2	11.8	0.5
1981	13.0	11.2	11.7	0.5
1982	12.8	11.0	11.8	0.5
1983	12.8	10.1	11.7	0.4
1984	12.9	9.6	11.4	0.4
1985	13.3	9.4	11.8	0.5
1986	13.3	9.5	11.6	0.4
1987	13.6	9.1	11.3	0.4
1988	13.8	9.0	11.4	0.4
1989	13.6	8.4	11.5	0.4
1990	13.9	7.9	11.2	0.3
1991	13.7	7.4	11.3	0.3
1992	13.5	6.6	11.0	0.3
1993	13.1	6.3	11.3	0.3
1994	12.9	6.2	10.7	0.2
1995	12.5	6.2	10.9	0.2
1996	12.5	6.1	10.9	0.2
1997	12.3	5.8	10.7	0.2
1998	12.1	5.7	10.6	0.2
1999	11.8	5.8	10.6	0.2
2000	11.4	5.6	10.2	0.2

Improved mortality rates

Mrs Lee is 87 years old and has a new great grandson. Joshua was born in December 2005. Mrs Lee has two adult children, four grandchildren and now a great grandson. This is very different from the family structure she knew as a child. Mrs Lee had been one of ten children. Two of her siblings died as babies. She never knew her grandparents. Both of her grandfathers were miners who had died before she was born. Both of her grandmothers died before she started school at the age of five. Her own parents had died in their seventies. Now there were four generations in the family and her friends were sharing similar stories.

Infant mortality rates are frequently used as an indication of a society's social and economic progress. A high infant mortality rate often indicates inadequacies in a range of social and economic services. Sadly, infant mortality rates are very much higher in developing countries than in the more prosperous countries of the northern hemisphere. In the United Kingdom they are significantly higher in the lower social class groups than in the higher social classes.

Figure 6 Reasons for the relatively high infant mortality rate in the lower social classes



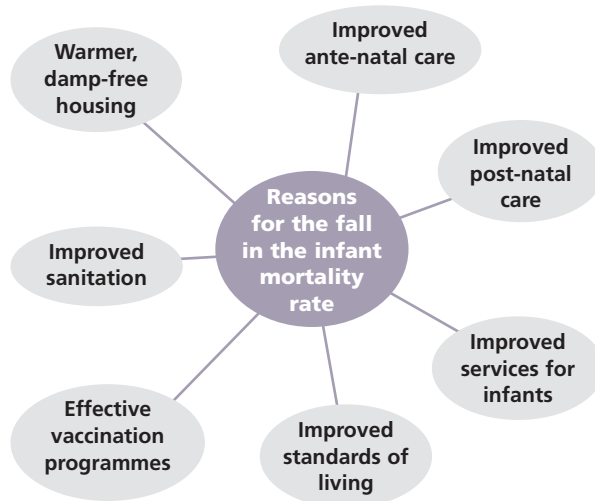
Despite improvements in sanitation and other areas of public health during Victorian times, the infant mortality rate stubbornly remained at about 150 per thousand live births. Only when poverty decreased and medical services improved was there a noticeable improvement. The introduction of penicillin and the further development of the immunisation programme during the Second World War further contributed to lower infant mortality rates.

Death rates have fallen for all social groups over

Figure 7 Factors that may lead to emigration



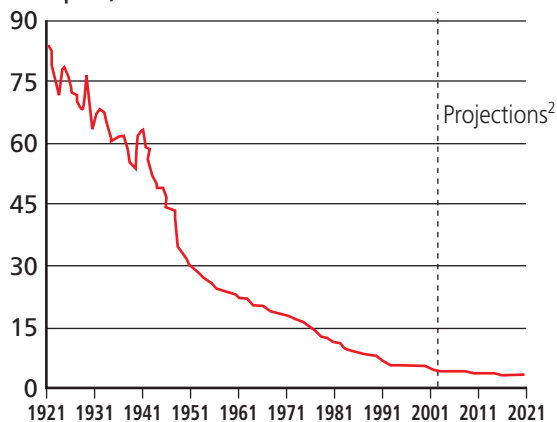
Figure 9 Reasons for the fall in the infant mortality rate



the past hundred years. There is, however, a continuing and growing difference between the expectation of life of people from different social groups. The expectation of life for women is longer than for men, and for people from higher social classes than for people from lower social classes.

The Black Report (1980) and the Acheson Report (1998) provide detailed and comprehensive evidence of the complex relationship between social and environmental factors and health, illness and mortality rates.

Figure 8
Infant mortality¹
United Kingdom
Rates per 1,000 live births



¹ Deaths within one year of birth.

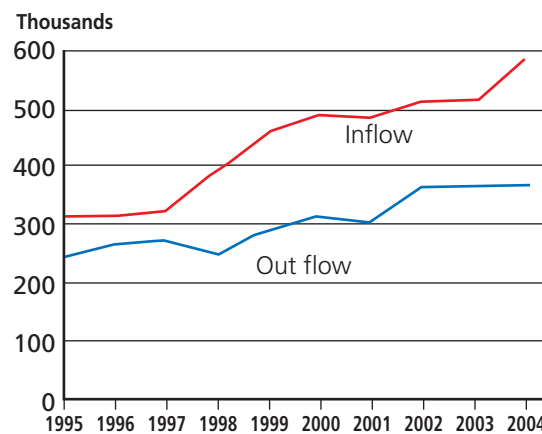
² 2002-based projections for 2003 onwards.

Source: Office for National Statistics

Marriages like this one celebrate Britain's ethnically diverse population

Immigration and emigration

Figure 10
International migration into and out of the UK 1995–2004



Source: Office for National Statistics



In 1991, which was the first time that a question on ethnic origin was included in the census, the proportion of people from minority ethnic groups was 5.5%. Britain has, however, been a country of many races for centuries. Mostly the immigrants have been refugees escaping religious and political persecution – the French protestant Huguenots in the seventeenth century, and the Jews since the time of Oliver Cromwell, and particularly during the 1880s and 1890s, and in the 1930s escaping persecution in Europe. In the Second World War, a wide range of national groups – such as the Poles and Czechs, and Commonwealth citizens from the Caribbean, India and Pakistan – served with the British forces. Some stayed in Britain after the war. Others, particularly people from the Commonwealth, were encouraged to come and work in Britain. Employers in the textile industries recruited more particularly from India and Pakistan. In the late nineteenth century and the early years of the twentieth century the number of people leaving the UK had been greater than the numbers coming to live here. For most years since the early 1930s, however, more people have immigrated than emigrated to other countries.

Following the expansion of the European Union in 2004, to include the Czech Republic, Cyprus, Latvia, Lithuania, Malta, Estonia, Hungary, Poland, Slovakia, and Slovenia, there has been increased migration from these countries to the United Kingdom. According to Home Office figures published in August 2005, a total of 232,000 Eastern European migrants had registered to work in Britain between May 2004 and June 2005. The overwhelming majority of those seeking work were young, with 82% aged between 18 and 34. Only 5% of registered workers had dependants living with them in Britain. Home Office statistics also show that between July 2004 and June 2005, 5,500 European migrants had taken jobs within the care sector, mainly as care assistants. However, there were

also 560 teachers, researchers and classroom assistants, 290 hygienists and dental nurses, and more than 300 doctors, nurses and specialists. The employment and care of the new wave of European migrants poses new and specific issues for the care sector. These are discussed in Topic 4 and relate to ensuring equality of opportunity and access to the services provided.

In 2004 the government introduced 'Citizenship ceremonies' for migrants to the United Kingdom. The government holds a view that through these ceremonies foreign nationals taking British Citizenship are able to demonstrate and confirm in public their commitment to the country. Since 2005 applicants have been required to also take a citizenship test. This tests the person's knowledge of British political institutions, aspects of the law, sources of help and assistance – including access to health and care services, and their understanding of everyday activities such as how to pay bills.

Check your understanding

- 1** Identify and explain the most likely reasons for the fall in the birth rate during the twentieth century.
- 2** Identify and explain the most likely reasons for the fall in the death rate.
- 3** Why might infant mortality rates reflect levels of social and economic progress in a society?
- 4** What is meant by the term 'net migration'?
- 5** Identify three reasons why groups of people may choose to emigrate.

extension activities

- 1** From your own general knowledge, or by using resources in your library or the internet, identify the main ethnic minority groups in the UK.
- 2** Consider how the managers of a day nursery can ensure that people from all community groups are welcome.

Topic 3

An ageing society

Getting you thinking

- 1 Describe the stereotypical image of an older man or woman that you have seen presented in a television programme.
- 2 Do you think that older people are respected members of the community in which you live?
- 3 Explain how people such as those in the picture can counteract the stereotypical images of retirement and old age that exist in society.
- 4 What health and welfare needs do you associate with old age?



KEY TERMS

Ageism

Attitudes and behaviour which discriminate against people because of their age.

Community care

Provision where people should be cared for in their homes or in small 'family' units rather than in large, less personal institutions.

Age discrimination

Treating people differently (and normally less well) on the basis of their age.

Life expectancy

A statistical measure which predicts the average number of years a person is likely to live. This could be estimated from any particular age, but is usually expressed as from birth.

Extended family

A family group of normally three or more generations who form a close-knit network, and provide support and care for members.

Morbidity

The incidence of chronic ill health and disease.

Nuclear family

The small family unit of two generations – parent(s) and their children.

An ageing population

Earlier in this unit we noted the changing age structure of the population and specifically the increased proportion of older people in our society. In this topic we are going to consider the implications of an ageing population and the sources of support for older people.

'Simply to grow old is not in itself a problem' says Muriel Brown in her book *Introduction to Social Administration in Britain*. Ageing is a natural process that affects us all. It leads to slower physical and cognitive responses, some poorer vision, less acute hearing and some loss of energy and increased frailty. This is *not*, in itself, a problem – but limited support for people in their older life may well be.

Many people in retirement live full and active lives – continuing in paid work, working as volunteers and enjoying their additional leisure time. Those over 85 years of age are more likely to need support. For those with poor health, and especially if they are on low incomes, older age can be lonely and depressing. This is not a comment on old age itself, but rather a comment on the support available and our response to the vulnerable.

In 2003, according to estimates based on the 2001 census, there were over 11 million older people in the population. This is expected to increase to 11.4 million in 2006, and 12.2 million in 2011 – and it will rise to nearly 14 million by 2026 (www.ace.org.uk/Ageconcern). Further, the older population is ageing. Within the population aged 65 and over, the proportion of people aged 85 and over has increased from 7% in 1971 to 12% in 2004 (ONS www.statistics.gov.uk/cci/nugget.asp?id=881).

In many societies, older people (the elders) have high status and have an important role in the family and in the wider community – notably in China, India and many parts of Africa, and within Muslim, Hindu and Sikh communities. In modern Britain, however, it could be argued that older people are less central to our way of life, both in the family and in the wider community.

Figure 11 Life expectancy and healthy life expectancy at birth: by sex

United Kingdom

	1961	1991	2003
Males			
Life expectancy	67.8	73.2	76.2
Healthy life expectancy	...	66.1	...
Females			
Life expectancy	73.6	78.7	80.5
Healthy life expectancy	...	68.5	...

Source: Government Actuary's Department; Office of National Statistics

In 2004, Age Concern, in partnership with the University of Kent, undertook a research programme exploring the extent of prejudice and discrimination about age and ageing. They found that:

- More people (29%) reported suffering **age discrimination** than any other form of discrimination.
- From age 55 onwards, people were twice as likely to have experienced age prejudice than any other form of discrimination.
- Nearly 30% of people believed there is more prejudice against the old than five years ago, and that this will continue to get worse.
- One third of people thought that the demographic shift towards an older society would make life worse in terms of standards of living, security, health, jobs and education.
- One in three respondents said they viewed the over 70s as incompetent and incapable.

How ageist is Britain? Age Concern 2004

There has been no legislation in place to prevent discrimination against people on the basis of their age, but the European Directive on Equal Treatment (2000/78/EC) will require all member states to pass legislation which will outlaw discrimination in employment and training on the grounds of age. This is scheduled to be implemented in October 2006, extending further the equality legislation in the UK.



Older people have high status and an important role in African families like this one.

The family and the care of older people

In the societies and cultural groups where older people are particularly well respected they often live in an **extended family** – where a wide kinship network is expected to provide support for the family. In modern Britain, however, the likelihood of living alone increases with age. In 2002, 48% of those 75 years of age and over were living alone, compared with 12% aged 25–44 (www.ace.org.uk/AgeConcern). Changes in our society have arguably, however, made it more difficult for families to easily provide support for the dependent elderly, for several reasons:

- Families are smaller than they used to be. The average number of children in families has fallen (*Social Trends*). There are fewer adult children to share in the responsibilities of care and support.
- There have been changes in the position and status of women in society. Far more women are in paid employment and unable to provide daily care for dependent relatives.
- Far fewer families live near their elderly relatives than was the case 50 years ago, and this provides serious difficulties in providing care for the frail and vulnerable.
- The proportion of adult children who live with their parents or other older family members is very small.
- The complications and stress that arise from the increase in family breakdown and divorce make caring for the vulnerable elderly more difficult.
- There was, arguably, some change of attitude towards the care of older people in the years following the Second World War, with the development of a welfare state. It was assumed that older people would be cared for by the state. It was not necessary for adult children to be relied on for their care.
- The cost of caring for older people by adult relatives has not been fully addressed by the state. Benefits for carers have never been sufficient to compensate for the loss of potential earnings.
- Housing policy has not addressed the potential need for caring for older relatives. Three-bedroom houses with a 'through lounge' are not well suited to caring for elderly relatives.
- Employers are not required by law to agree flexible working arrangements for employees who are also caring for vulnerable relatives.

Gordon Lishman, Director General of Age Concern England, is quoted as saying:

'...carers are caught in a no-win situation. If they give up work they face poverty. If they keep their jobs, they must struggle with unrelenting hours'

(www.ageconcern.org.uk).

Poverty and older age

There have been numbers of studies pointing to the higher incidence of poverty amongst older people compared to the population as a whole. On reaching retirement age, most people give up their full-time employment and are then dependent on income from their pensions and from savings.

Economic well-being in older age is closely linked with prosperity whilst in employment. Those who have enjoyed good wages, little unemployment, and occupational pension plans enjoy greater financial security in older age than those who have had interrupted employment and lower wages. Because of this, women, who make up the larger proportion of the older population and experience longer periods of ill health (**morbidity**) in older age also experience greater financial hardship. They are less likely to be

The lives of the affluent and the poor

Sally, who is 14 years of age has four grandparents all of whom are retired and in their late sixties. Sally's mum's parents seem to be having the time of their life. They were both doctors and had a good income all their life and now have a good occupational pension. They have a beautiful home. They play golf, go on holiday abroad during the winter, take their grandchildren away during the summer holidays and really they just don't seem to age.

Sally's dad's parents, however, are not doing quite so well. Grandad was a steelworker and was made redundant in the 1970s. He managed to get other jobs but they were all poorly paid and there was no occupational pension. Grandma worked part-time as a cleaner but she didn't have a works pension either and she never paid in to the state pension scheme. They still live in the council house that they moved to when they got married. It is damp and difficult to heat. Sally knows that in the winter her dad's parents have to choose between spending their small pensions on eating well or keeping warm. They do manage to go away on holiday for a week in the summer but they have never been on holiday abroad.

entitled to a full state pension or have paid into occupational pensions. Their wages whilst in employment are likely to have been lower and they are likely to have had a more interrupted working pattern. Most women now in older age will have given up paid work when their children were small and are more likely than their husbands to have reduced their work pattern to care for older relatives. The state pension scheme does not compensate people (usually women) who have interrupted their employment to care for adult relatives.

Gordon Lishman (in the same speech as quoted above) said: 'Carers save the economy billions through unpaid work each year, and they need flexible working as much as parents do. At the same time our outmoded pension system needs sweeping reforms.'

Care of the vulnerable old

Most older people do not require any regular practical care support. They live independent lives in the community – often contributing more than they obviously receive. Where they do need help, notwithstanding the comments earlier in this section, the help is most likely to come from family, friends or neighbours. When help is from family, despite changes in attitudes and equality legislation, it is far more likely to be from adult daughters than from sons.

For much of the twentieth century, vulnerable older people whose families were unable to provide the practical help needed were generally cared for in large institutions, very often geriatric hospitals. Many of these hospitals had once been the local 'workhouse' and despite changes, care in the geriatric hospital was often linked with the sadness and stigma of the workhouse. From the 1960s onwards, there were a number of reports criticising the quality of care in these large institutions, but it was not until the 1990 NHS and Community Care Act that there was legislative support and resources allocated for planned care in the community. The system continues to be managed by local social service departments who,

following the assessment of **community care** needs, will purchase care services from a range of statutory, private and voluntary providers. The care for the older people may include home care services, meals on wheels, attendance at a day centre or lunch club, adaptations to their own home, or full-time care in a residential care home. Only very rarely will long-term care be provided in large institutions or hospitals.

Informal carers

Sue is in her late fifties and has just given up work to care for her elderly mother, Grace. Sue herself is not well, she has always suffered from arthritis and gets bad headaches when she is tired. Grace lives a bus ride away from Sue on the other side of town. Sue and her partner Brian live with their son Tom in a two-bedroom terraced house. The bathroom and toilet are upstairs and so it is difficult for Grace to even visit them. Sue has arranged for Grace to receive meals-on-wheels and also a daily home-help during the week. However, Sue and Brian also have to ensure that Grace has proper meals at the weekend and that there is someone there over night because Grace is nervous in the dark when she is on her own. They provide this care for her themselves.

- 1** What is meant by the term 'community care'?
- 2** Describe the types of community care services that may be provided for older people who need support with daily living activities.
- 3** Why may there be poverty in older age?
- 4** Explain why, in the twenty-first century, it may be difficult for adult children to provide practical care for older relatives.

extension activities

- 1** Using the internet, your library or your local benefits office, list the main welfare benefits available to older people, and describe how they may support care in the community policies.
- 2** Find out more about the statutory, voluntary and private provision which supports older people in your area.

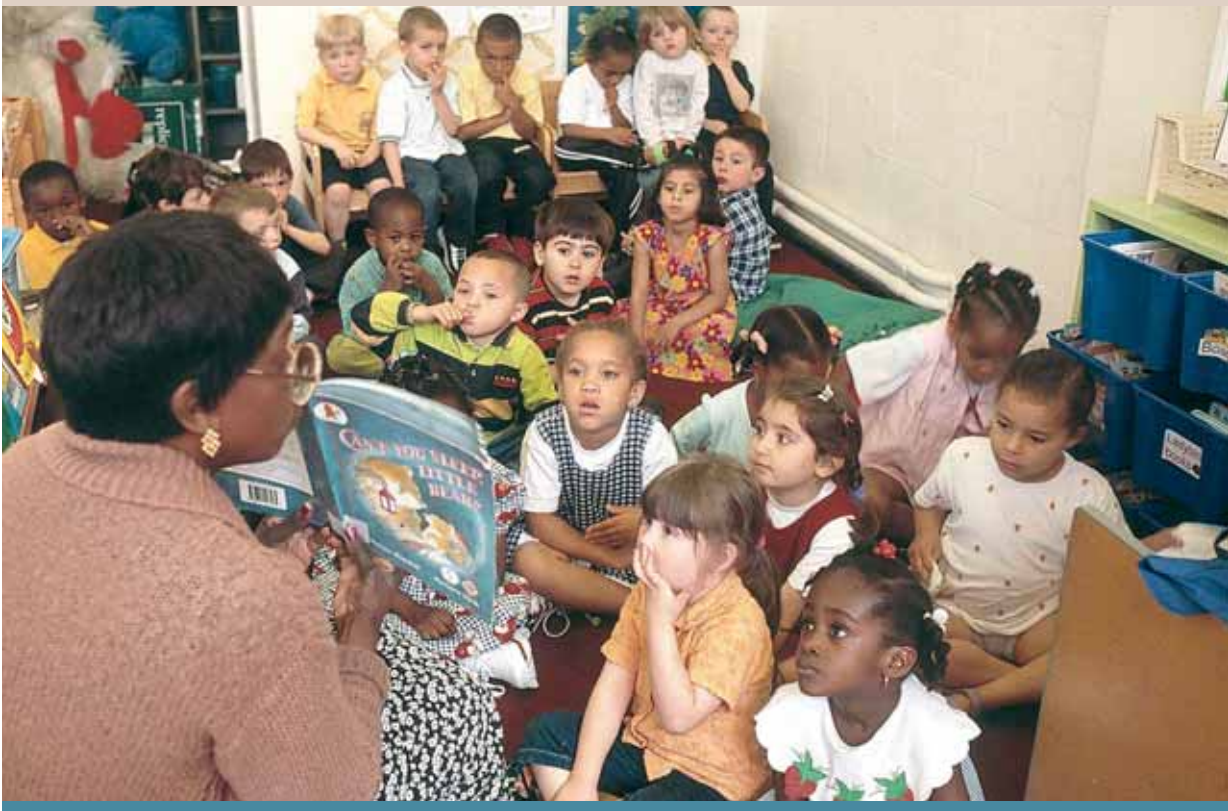
Topic 4

Discrimination and access to health and care services

Getting you thinking

Paul and Jane are opening a new nursery. They are currently advertising for staff in the local paper.

- 1 Should Paul and Jane make sure that the staff are from a range of ethnic backgrounds?
- 2 How do you think parents and carers will react to having a male nursery manager?
- 3 Should they put up notices at the nursery in a range of community languages, or should they encourage parents and carers to communicate in English?
- 4 Can you think of an occasion when you felt discriminated against? What did this feel like?
- 5 Is it too much to ask the nursery staff to meet the individual needs of all the children?



KEY TERMS

Discrimination

Treating people differently, and in this context normally less favourably, on the grounds of inherited or social categories, e.g. race, gender, sexual orientation or age.

Prejudice

Pre-judgements or preconceived opinions and ideas about a particular group, which are not modified in the light of new experiences of that group.

Statutory

Required by law.

Stereotype

An over-simplified image of the characteristics of a particular group, e.g. women are better at childcare than men.

Diversity

Diversity refers to differences, variety and contrast. Diversity focuses on our uniqueness as individuals and the obvious and subtle differences between us. Examples of the differences that are of social significance are differences in age, race and ethnicity, gender and sexuality, physical and sensory ability, religion and marital status. It is in these areas of difference that there has been specific action by governments – but they are by no means the only areas in which harassment and **discrimination** occur. Sometimes particular characteristics are associated with groups of people – that women are natural carers, for example, or that Africans have a great sense of rhythm, or that men are good at mechanics – and then all members of the group are expected to have these characteristics. These descriptions are **stereotypes** – they do not describe real individuals or address the diversity within groups. People who are stereotyped in this way can be discriminated against, because their individuality is not recognised. Each is simply treated as a member of a group with these perceived characteristics, and not as an individual.

In health and care settings, understanding the differences between people is necessary to:

- understand the needs of service users.
- meet the care needs of service users.
- ensure that information is clear and accessible to all service users.
- ensure that staff from diverse backgrounds and with specific individual needs are not isolated or misunderstood at work.
- encourage a wider range of people to work in the health and care services.

Diversity in this context is not about treating everybody the same, but it is about treating everybody with equal respect and care.

Equal opportunities

Views on equality of opportunity may be seen as falling into two main categories – those relating to equality of access to services and valued opportunities in society, and those relating to the possibility of equality of outcomes – that all individuals should be entitled to an equal share of the benefits.

Equality of access

Equal opportunities, in the context of policy making in modern Britain, has been mainly concerned with the first category – equal access for all – to employment and educational opportunities, our political institutions, and to the services that different organisations provide. All social groups should be provided with the chance to make the most of their talents and to use them for the benefit of the wider community. Policies have been aimed at removing the barriers that disadvantaged groups have found in achieving their potential and in accessing services. Across all parties and across the European Union there has been general and legislative support for equality of access. Most significantly there has been equality legislation in the UK:

- The Equal Pay Act 1970
- The Sex Discrimination Act 1975
- The Race Relations Act 1976 and the Race Relations Amendment Act 2000
- The Disability Discrimination Act 1995
- The Special Educational Needs and Disabilities Act (SENDA) 2001
- The Human Rights Act 1998

There have also been directives from the European Union:

- The Equal Treatment Directive 1976 for men and women.

This led, among other things, to the equalisation of retirement ages for men and women.

- The Equal Treatment Directive 2000 for religion or belief, disability, age or sexual orientation.

This led to discrimination on the grounds of religion, belief and sexual orientation in employment to become illegal in 2003 and discrimination on the grounds of age to become illegal in 2006. It is illegal to advertise jobs as open to young people only, and illegal to discriminate on the grounds of age when advertising and recruiting for posts, and in promotion and training.

Equality of outcome

Policies which support the view that everybody should be entitled to an equal share of society's benefits – which might include an equal share of wealth, income, quality of housing and education, and equal power and status – have been rare. There has been little political support for creating an equal society, but policy-makers in most advanced countries and

certainly in Europe (including the UK) have tried to remove barriers so that all people are treated fairly and have equality of access to a good education, good housing and a healthy life.

Government responses in areas of discrimination

The Equal Pay Act 1970 attempted to improve the position of women in employment by making it unlawful to discriminate between men and women in terms of pay and their conditions of work. Within any company, they should be paid the same if they are doing the same or similar work.

The Sex Discrimination Act 1975 made it illegal to discriminate on the grounds of sex or marital status in:

- employment
- education
- advertising
- housing
- the provision of goods and services, e.g. getting a mortgage or signing a credit agreement.

The Act identified two forms of discrimination: 'Direct discrimination' consists of treating a person less favourably on grounds of their sex or marital status, e.g. requiring that a child care worker should be female.

'Indirect discrimination' consists of imposing conditions – which are not relevant to the situation – on both men and women, married and single, that would be a barrier for people from some categories. An example would be advertising a plumbing course 'for all', but providing no toilet facilities for women and no provision for women needing maternity leave.

The Equal Opportunities Commission was set up under the Sex Discrimination Act, and has a general remit to secure equality of opportunity on grounds of sex and marital status:

- It runs high-profile campaigns on gender issues aimed at changing public opinion (and the law).
- It publishes research about the relative positions of women and men to show clearly where change is needed.
- It investigates companies and other organisations where unlawful practice is persistent.
- It takes legal action under the Sex Discrimination Act and the Equal Pay Act to secure equal rights for women and men.

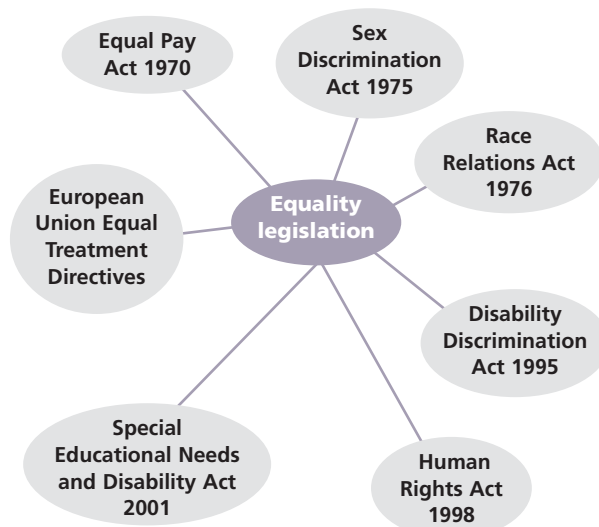


Figure 12

The Race Relations Act 1976 strengthened two previous laws of 1965 and 1968. It has a very similar structure to the 1975 Sex Discrimination Act, and makes it illegal to discriminate on grounds of race, colour, nationality and national or ethnic origin. As with the Sex Discrimination Act, it provides protection in the fields of employment, education, training, housing and the provision of goods, facilities and services.

The Race Relations (Amendment Act) 2000 went further:

- prohibiting race discrimination in all public places.
- requiring public bodies (which includes all state-funded schools and care settings) to promote race equality.

The 'public bodies' are expected to provide evidence that they are carrying out their duty to:

- eliminate unlawful racial discrimination.

Discrimination in employment

Lola worked as a clerical assistant in a medium-sized engineering company. Following a serious car accident on holiday she needed to use a wheelchair at work. The company were initially sympathetic but then gave her notice that she was being made redundant. The premises, they said, were not suited to wheelchair users. Lola knew about the Disability Discrimination Act (1995) and contacted her local Citizens' Advice Bureau (CAB). The CAB wrote to the company on her behalf pointing out their responsibilities to 'make reasonable adjustments to their premises' for people with disabilities. They reminded the company that Lola had the right to take her case to an employment tribunal should she consider their response to be discriminatory.

- promote equal opportunities.
- promote good relations between people from different races.

The publicly funded organisations should make race equality a central part of the way that they work, by putting it at the centre of their policy making, service delivery and employment practice.

The Commission for Racial Equality, set up under the Race Relations Act 1976, forms a very similar function to the Equal Opportunities Commission, with a general remit to promote equal opportunities for members of all racial groups. In practice, of course, most discrimination is against people from minority ethnic groups, and it is those groups who directly benefit from their work.



Figure 13 Ways of promoting race equality in care settings

The Disability Discrimination Act 1995 defines disability as 'a physical or mental impairment which has a substantial and long-term adverse effect on [someone's] ability to carry out normal day-to-day activities'. The Act was passed with the aim of ending the discrimination that people with disabilities were facing. It gives disabled people rights in the areas of:

- employment
- access to goods, facilities and services
- buying or renting land or property.

(Adapted from www.disability.gov.uk)

Since 1996, under Part 2 of the Act – which focuses on employment – it has been unlawful to discriminate against someone with a disability as a job applicant or as an employee:

- by treating him or her less favourably (without justification) than other employees or job applicants because of his or her disability.
- by not making reasonable adjustments.

Under Part 3 of the Act – which addresses the access to goods, facilities and services:

- It is unlawful to treat a person less favourably because they are disabled.
- Service providers have to consider making reasonable adjustments to the way they deliver their services so that people can use them.
- Service providers have to consider making permanent physical adjustments to their premises.

The Disability Discrimination Act is different from the Sex Discrimination Act and the Race Relations Act in a number of ways. Generally there is not as strong a requirement for equal treatment as in the other equality legislation. First, the Act applies only to employers with fifteen or more employees. Secondly, there is no reference in the legislation to 'indirect' discrimination and, thirdly, employers and service providers are required only to make 'reasonable' adjustments. What is reasonable will be open to debate, and may have to be tested in the courts or at an Employment Tribunal.

The Special Needs and Disability Act 2001 introduced the right for school pupils and students with disabilities not to be discriminated against in education and training. This includes a wide range of linked services – such as field trips and other school outings, examinations, arrangements for work placements and access to libraries and other learning resources.

The Disability Rights Commission was set up in 2000 to replace the less powerful Disability Rights Council established in 1996. The Commission's goal is to see 'a society where all disabled people can participate fully as equal citizens'. Its functions are very similar to the those of the other equality commissions:

- giving advice and information to disabled people, employers and service providers.
- supporting disabled people in getting their rights under the Disability Discrimination Act.
- providing legal assistance, as appropriate.
- campaigning to strengthen the law.
- producing policy statements and research on disability issues.

(See www.drc-gb.org.)

The provision of additional learning support

Wayne is nine years old and attends Woodgreen Primary, his local infant school. He is making good progress in numeracy but very slow progress in reading and spelling. His writing is very untidy and he is beginning to lose confidence. The Headteacher of Woodgreen Primary thinks that Wayne's parents are fussing but has agreed to discuss the issues with them. The school's Special Educational Needs Co-ordinator is going to be at the meeting.

Following the meeting it was agreed that an educational psychologist would be asked to assess whether Wayne might be dyslexic and, using this and other information they have on Wayne's progress, agree an Individual Educational Plan to provide appropriate support for him.

The Human Rights Act 1998, which came into force in 2000, incorporated most of the articles of the European Convention of Human Rights into our domestic law. Those areas covered by the Act are:

- Right to life (Article 2)
- Prohibition on torture (Article 3)
- Prohibition on slavery and forced labour (Article 4)
- Right to liberty and security (Article 5)
- Right to a fair trial (Article 6)
- No punishment without law (Article 7)
- Right to respect for private life and family (Article 8)
- Freedom of thought, conscience and religion (Article 9)
- Right to freedom of expression (Article 10)
- Freedom of association and assembly (Article 11)
- Right to marry and found a family (Article 12)
- Prohibition of discrimination (Article 14)
- Protection of property (Article 1 of the First Protocol)
- Right to education (Article 2 of the First Protocol)
- Right to free elections (Article 3 of the First Protocol).

The European Directive on Equal Treatment (2000/78/EC) requires all member states to pass legislation which will outlaw discrimination in employment and training on the grounds of age, sexual orientation, religion and belief, and disability. This is scheduled to be implemented in October 2006, extending further the equality legislation in the UK.

As what may be seen as a natural development from the European Directive (2000/78/EC) the government plans to set up, in 2007, a new Commission for Equality and Human Rights (CEHR) which will replace the Disability Rights Commission, the Commission for Racial Equality and the Equal Opportunities Commission. The aim of the new Commission will be to widen scope and end discrimination and harassment in areas of disability, race, age, gender, religion and belief, and sexual orientation. The government believes that a single commission will:

- bring together equality experts, and act as a single resource of information and advice – instead of the separate organisations.
- provide a single point of contact for individuals, businesses and the voluntary and public sectors.
- help businesses by promoting awareness of equality issues, which may prevent costly court and tribunal cases.

- tackle discrimination on multiple levels – some people may face more than one type of discrimination.
- give older people a powerful national body to tackle age discrimination.

In September 2005, the Home Secretary, Charles Clarke, announced plans for a 'Commission on Integration', not to replace the equality commissions, but a separate commission that would aim to foster healthy, mixed communities with shared norms and patterns of behaviour. The aim is to develop practical ways to overcome the barriers to integration. Trevor Phillips, the Chair of the Commission for Racial Equality had claimed that Britain was increasingly dividing on racial lines, living in segregated communities, and 'sleepwalking into apartheid'.

Check your understanding

- 1** Define the following terms: prejudice, discrimination, stereotype, diversity.
- 2** Why is it necessary to understand individual differences when supporting people in health and care settings?
- 3** Which groups of people are protected from discrimination by law?
- 4** What is the difference between direct and indirect discrimination?
- 5** What are the main functions of the equality commissions?

extension activities

- 1** Using the internet, check the main functions of the proposed Commission for Equality and Human Rights. If they have changed from the proposals outlined in this section, make a poster for your classroom with the up-to-date information.
- 2** Collect a copy of the equal opportunities policy of any organisation that you are involved with, e.g. school, college, workplace or work placement. Examine how far the objectives or policy statements are met.

Topic 5 An unequal society

Getting you thinking

- 1 'There are plenty of opportunities for everyone. Nobody needs to be poor these days.' Is that how it is?
- 2 Are we all middle class now?
- 3 Is it true that we're all far better off than our grandparents' generation were?
- 4 Are some groups always excluded from the good things on offer?



KEY TERMS

Social stratification

The grouping of people together according to their perceived status or rank within society.

Egalitarian society

A society in which everyone is regarded as equal.

Social class

There are many competing definitions of social class. Central to all definitions is the idea that position in society is determined by our economic circumstances, which will then influence our life choices, our opportunities and future prospects

Social exclusion

A term used to describe a situation where people are unable to participate fully in society for a number of related reasons – including poverty, unemployment, poor housing (or homelessness), poor health and poor educational achievement.

Underclass

Coined by Gunnar Myrdal (1969) and closely linked with the idea of social exclusion, this term is normally used now to refer to the people in poverty who are excluded from fully participating in society because of the social and economic changes that are outside their control.

Prejudice

A strongly held attitude towards a particular group which will often persist, even when shown to be unjustified or unfounded.

Discrimination

Treating a person or a group of people differently (usually less favourably) than others.

Stereotype

Defining a group of people – black people or lone parents, for example – as if they all possess the same personal characteristics, ignoring their individual differences.

Labelling

Closely linked with stereotyping. When a person is 'labelled' then usually the stereotypical characteristics of that group are applied to them, and their individual characteristics are ignored.

Inequalities in society

Inequalities in our society are well documented by social scientists, journalists and government statisticians. The observable consequences of inequality, though, are probably all too visible in everyday life. They are seen in the range of housing in modern Britain, the contrasting environments within towns and cities, differences in schools and children's educational achievements, and differences in individual levels of wealth and income. These inequalities are reflected in the fact that:

- Children from manual social backgrounds are 1.5 times more likely to die as infants than children from non-manual backgrounds.
- Babies from manual social backgrounds are 1.3 times more likely to be of low birth weight than those from professional backgrounds.
- Teenage motherhood is six times as common amongst those from manual social backgrounds as for those from professional backgrounds.
- Forty per cent of lone parents are not in paid work.
- Overcrowding is more than three times as prevalent in social rented (local authority and housing association) housing as in owner-occupied housing.
- People of black Caribbean, Bangladeshi and African ethnicity are twice as likely to be out of work (and wanting work) as white people.

(www.poverty.org.uk)

Social stratification

Social stratification is a term that sociologists have adapted from geologists' terminology, where 'stratification' refers to the different layers of rock, one on top of another. Almost all known societies have had a concept of some groups being of higher status than others. In America, before the civil war, groupings in the South were based on race. In feudal Britain, land ownership was a key determinant of status.

Hindus have a strict hierarchy of social 'castes', with the Brahmin (the priestly caste) regarded as the most superior and the Sudras (the labouring caste) considered to have the least status. Beneath the Sudra caste are the casteless – the 'untouchables', a group now theoretically prohibited by the Indian government, but still of considerable actual significance.

Those in the higher social groups are normally more wealthy and have access to a quality of life valued within that society. There have, however, been experiments in establishing unstratified, more

egalitarian societies. Probably the best known and most developed example is the kibbutz system in Israel. There are currently about 240 kibbutzim in Israel, with populations of several hundred each. All property and land are communally owned, and all goods are distributed to members according to their need. Children are brought up and educated communally. Money is not normally used. General assemblies are held to discuss and make major decisions. Studies of kibbutzim, however – most notably by Eva Rosenfeld (1957) – have suggested that there is some stratification, particularly between the leaders, elected to run the kibbutzim and the 'ordinary' members who carry out the tasks.

Social class

Most modern societies today are stratified by **social class**, a system based largely on economic factors linked with income and wealth. In modern Britain, most research into the impact of social class on health and well-being has used occupation to locate people's class position. Occupation has long been seen as closely linked with level (and security) of income, and also with people's standing in the community.

Since 1911, the census data has been analysed by class categories, based on occupation. This system, which was usually known as the 'Registrar General's Scale' (the Registrar General being the head of the Office for National Statistics) remained largely unchanged until 1991, and consisted of six 'social classes':

- 1 Professional occupations, e.g. architect, accountant, doctor, judge, optician
- 2 Managerial and technical occupations, e.g. farmer, nurse, school teacher,
- 3 **(non-manual)** e.g. clerical worker, secretary, shop assistant
- 3 **(manual)** e.g. bricklayer, bus driver, carpenter, cook, police constable
- 4 Semi-skilled occupations, e.g. bar person, postman, bus conductor, farm worker
- 5 Unskilled occupations, e.g. chimney sweep, office cleaner, window cleaner.

For the 2001 census a new occupational classification was introduced, which is thought to be more flexible, and which includes those people who are not in paid work:

- 1.1 Employers and managers in large organisations, e.g. managing director

- 1.2 Higher professionals, e.g. doctors, solicitors, teachers
- 2 Lower managerial and professional occupations, e.g. nurses, journalists
- 3 Intermediate occupations, e.g. clerks and secretaries
- 4 Small employers and own account workers, e.g. taxi drivers, painters and decorators
- 5 Lower supervisory, craft and related occupations, e.g. plumbers and electricians
- 6 Semi-routine occupations, e.g. shop assistants, hairdressers
- 7 Routine occupations, e.g. cleaners, refuse collectors
- 8 Those people who are not in paid employment.

These systems of classification – and others which are very similar in structure – have been used to analyse research into levels of poverty and the impact of social class on a wide range of social and economic activities, including the inequalities identified at the beginning of this section.

Social exclusion

Social exclusion is a term closely linked with issues of poverty and deprivation, but it refers to wider issues of participation in society. The Social Exclusion Unit, set up by the Labour Government in 1997, describes ‘social exclusion’ as a shorthand term for what can happen when people suffer from a combination of linked problems, such as unemployment, poor housing, poor skills, low income, high crime environments, bad health, poverty and family breakdown.

The Social Exclusion Unit was set up to address perceived social problems, which were seen as having interlinked causes, and therefore needed co-ordinated solutions. They were looking for ‘joined-up solutions to joined-up problems’. Tony Blair when launching the unit was quoted as saying that social exclusion is ‘about more than financial deprivation. It is about the damage done by poor housing, ill-health, poor education, lack of decent transport, but above all lack of work.’ (quoted in Tossell, D. and Webb, D. (2000) *Social Issues for Carers*). Unemployment – especially prolonged unemployment – was seen as a crucial factor in individuals and their families becoming excluded from the social, economic and political life of society.

The term ‘social exclusion’ has come to replace a closely linked concept of the **underclass**, a term you may come across in some sociology and social policy texts. Both these terms are used to describe people who are ‘on the edge’ of our society, and not able to

Social exclusion

Joe and his friend Winston are 20 years old. They have never managed to obtain paid work. Both grew up in an area of high unemployment. Joe and Winston’s parents were all made redundant along with many of their neighbours when the local coal mine closed. They have been unable to find paid work since. There is over 30% unemployment on the estate where Joe and Winston live and little chance of this improving. Because both of them stopped going to school regularly in year 10 neither has any GCSEs. They didn’t see the point at the time because there was no work or jobs for them to get anyway. Joe and Winston have a very negative view of the future and don’t believe that they have any real opportunities in life. They have no training, they have never voted, they are not part of any organised community groups and admit that they are just drifting into the future with no plans, no ambitions and few prospects.

take a full part in economic, political and social life.

The overall effect of the interrelated causes and consequences of social exclusion is to ‘marginalise’ those individuals and groups in our society who are not able to fully participate. Marginalised groups will normally lack the income to take a full part in the economic and social life of our society.

Those groups are likely to be the subject of **prejudice**. This term is not easy to define, but it refers to strongly held beliefs and attitudes about people which often have no basis in factual evidence, but which are held so *strongly* that they are difficult to shift. The beliefs and attitudes are often directed at disadvantaged groups, and usually attribute negative characteristics to them. People who have prejudicial attitudes to specific groups rarely look for robust evidence to support their view – and even when it is presented to them it rarely makes any difference.

This process is closely linked to stereotyping. A **stereotype** is a set of characteristics that members of a particular group are said to possess, e.g. ‘that all hoodies are school drop-outs, they often shoplift and they cannot be trusted’. People who have been stereotyped tend not to be seen as individuals but as a typical member of the group. When a stereotype is widely held it is sometimes said that the individual or group has been **labelled**, because the stereotypical characteristics are routinely applied to them.

It will be becoming clear how prejudicial attitudes and stereotyping can lead to **discrimination** or discriminatory behaviour. If we have negative attitudes towards a particular group we are likely to be wary of

them and treat them less favourably than other members of society.

Social exclusion will potentially lead to a range of negative consequences for the social, emotional, intellectual and physical development of the people affected. They are likely to become socially isolated because they are marginalised. They also are unlikely to have the income which will support an active social life. This is likely to lead to a poor self-image, low self-esteem and little self-confidence. These social, emotional and economic circumstances will not easily support educational success, and are likely to impact negatively on general health and well-being, and physical health in particular.

Check your understanding

- 1** Define the terms **social stratification, social class, social exclusion.**
- 2** Describe the social issues that the government tried to address through the **Social Exclusion Unit.**
- 3** Explain why prejudice may lead to **discrimination against disadvantaged groups in our society.**
- 4** Explain why the idea of **stereotyping and labelling** may be seen as closely linked.

extension activities

- 1** Working with another member of your group, try to describe how a society could operate if everybody was equal. What would be the advantages and disadvantages of an equal society?
- 2** The government has identified that people vulnerable to social exclusion include the homeless and people in poor housing, the unemployed, people with poor educational qualifications and people on low incomes.

Find out more statistics on these areas of people's lives. Try to establish whether trends are improving or not. Discuss with other members of your group how you would address the problems.

Topic 6

Poverty and welfare support

Getting you thinking

- 1 Write a list of items that you think are essential – and without which you would be in poverty.
- 2 Compare this with your friends' lists.
- 3 In your own words, write a definition of poverty.
- 4 Which groups in our society do you think are most likely to be in poverty?
- 5 What are the main consequences of poverty in the United Kingdom?



KEY TERMS

Absolute poverty

A level of income below that which will sustain good health.

Culture of poverty

A view that poverty is associated with a particular (and separate) way of life that is passed on from generation to generation.

Means-tested benefits

Welfare benefits that are only available to people if their income and savings are below a certain level, decided by the government.

Poverty line

A term, introduced by Seebohm Rowntree, which set a level of income below which people were said to be in poverty.

Relative poverty

Relative poverty occurs when people live below the standard of living normally accepted in a particular society.

Universal benefits

Welfare benefits to which people are entitled, regardless of their income or savings.

What do we mean by poverty?

In this topic we will discuss what we mean by poverty, and how difficult it is to measure poverty. We will then consider why, in a wealthy nation like ours, poverty still persists and, finally, how governments have responded to the identified needs of the poorest in our society.

It will be no doubt be clear when comparing your lists of 'essentials' that it is difficult to agree on what we mean by 'poverty'. And if we cannot easily define a term, we will have great difficulty in measuring the extent of the problem – or even if the problem exists.

The first systematic studies of poverty in England were conducted by social reformers at the turn of the nineteenth century. Charles Booth (1840–1916) in his study, *Life and Labour of the London Poor*, and the Quaker Seebohm Rowntree (1871–1954) in his study of York, *Poverty: A study of town life*, exposed the existence of widespread poverty in these two cities. These studies were important, not only in their own right, but also in their continuing influence. They provided evidence and an approach to understanding poverty, which has influenced government policies, and also provided an approach to defining and measuring poverty which has influenced the subsequent research in this area.

Booth covered a wide range of issues which have become central themes in studies of poverty, including employment, health, housing, religion and the level of wages. He was probably the first to identify the close links between poor health, disability, poverty, poor housing, unemployment and bad working conditions.

Rowntree (probably better known for his chocolate factory which was a main employer in York at the time) developed a vocabulary for discussing poverty which has informed discussion since. He introduced the idea of a **poverty line** – a concept that is still used by governments, and informs our benefit system today. It identifies a level of income below which people are regarded as living in poverty.



Figure 14

Rowntree defined people as poor if their income was such that the resulting deprivation had a detrimental effect on their health. With the assistance of the British Medical Association, he calculated the income that was necessary for the members of a household to maintain 'physical efficiency'. If their income was below this level they were regarded as in **absolute poverty**. The income allowed a basic diet that would be adequate, but no more. There was no allowance for papers or magazines, or alcohol, or travel. There was no allowance for stamps for writing to children living away from home. Families were regarded as in 'primary poverty' if their income was below the level that would maintain physical efficiency, and in 'secondary poverty' if their income would have been sufficient had they not spent money on items not on his list. This distinction could be seen as pointing to the idea of the 'deserving poor' and the 'undeserving poor'.

Rowntree conducted further studies in 1936 and 1950 where the understanding of poverty suggested that there was more to being poor than simply not being able to keep the body intact – social and emotional health were significant too. The 1936 study allowed that, to be above the poverty line, people should have an income sufficient for a radio, newspaper, beer and a holiday.

Later studies of poverty developed further the idea that poverty could be regarded as a level of income below which people were 'not able to participate in the life of the community'. The level, then at which a poverty line may be set would vary from community to community, and at different times in history. In some parts of Africa, for example, to have suitable shelter and regular meals would be regarded as rich indeed. In modern Britain people would normally regard this as not enough to count as playing a full part in the community. Peter Townsend (1979) was key in the development of the idea that the idea of poverty should be related to the society in which people live. He developed the idea of **relative poverty** (relative deprivation), claiming that:

'Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged or approved in the societies to which they belong . . . they are in effect excluded from ordinary living patterns, customs and activities.'

Townsend P. (ed.) (1979) Poverty in the United Kingdom

This approach to poverty was taken further by Mack and Lansley (1985, 1991) in their major studies *Breadline Britain*, defining poverty in relative terms.

They attempted to define poverty by asking their respondents what they considered to be necessities in modern Britain. An item was considered a necessity if more than half the respondents classified it as such. On the basis of this list of 'perceived necessities', Mack and Lansley measured the extent of poverty. In these, they took account of personal choices, asking respondents whether they lacked an item out of 'choice' or 'necessity'. Some people, for example, might choose to not have a television or a telephone in their home. Mack and Lansley found that generally, where people lacked three or more 'necessities' it had little to do with choice. It was unavoidable – they just couldn't afford them. This approach has been used since.

The most recent attempt to update the *Breadline Britain* studies was the 1999 'Poverty and Social Exclusion Survey of Britain' produced by the Office of National Statistics, supported by the Joseph Rowntree Trust. The aim of this study was to:

- Update the *Breadline Britain* surveys.
- Estimate the size of groups of households in different circumstances.
- Explore movements in and out of poverty.
- Look at age and gender differences in experiences and responses to poverty.

Over 90% of the population in this survey regarded a bed and bedding for everyone, warm living areas of the home, a damp-free home, the ability to visit family and friends in hospital, two meals a day, and medicines prescribed by the doctor as necessities.

The researchers found that a quarter (26%) of the British population was living in poverty measured in terms of low income and multiple deprivation of the agreed necessities.

(Adapted from www.bris.ac.uk/poverty/pse.)

A 'working definition' of poverty is still necessary to identify the extent of need, and then to address the issues. Some nations, including the United States, use a 'budget standard', based on the cost of a minimum basket of food (following Rowntree's idea). The UK and other members of the European Union set a poverty line at 50% of the median income. (The median is the mid-point of the full range of incomes in the population.) Those with an income of less than 50% of this amount are deemed to be in poverty.

Despite all these differences in definition, for those people on low incomes – perhaps having to choose between eating well and keeping warm – poverty is all too present.

Culture of poverty

Oscar Lewis, an American writer, is identified as the author most closely associated with the idea of a **culture of poverty**. He thought that poverty was associated with a particular, separate, way of life that was passed on from generation to generation. He thought that in order to cope with their stressful circumstances the poor were unlikely to plan for the future – they rarely saved, they had a less well ordered life, and a more fatalistic attitude to the future. Their culture and way of life was different to the mainstream in the society. A similar idea was developed in the 1970s through the concept of the 'cycle of deprivation' in which it is said that the lifestyle of the poor was passed on from one generation to the next. There is, however, little evidence to suggest that the poor have values and aspirations that are significantly different from the rest of society. They shop largely in the same high street, they are subject to the same advertisements, and similar demands are made by their children. As a result, they have a keen sense of being amongst the least well off in modern Britain.

Welfare benefits concerned with poverty

This section considers the benefit system aimed at supporting those identified as being in financial poverty. The structure of the benefit system can be traced back to the system set up following the Beveridge Report, and specifically to addressing issues of 'want'. Writing at a time of almost full employment, he saw poverty as generally caused by two things – first, the loss of income caused by the old age, unemployment, ill-health, or death of the family's main wage earner (at that time almost always the man) and, secondly, the cost of children.

The benefit system was to be largely financed by a new 'National Insurance' scheme to which people would contribute when they were in work and from which they were able to claim when they were unable to work. This meant that they would claim retirement pension when they were too old to work, sickness benefit when they were too ill to work, and unemployment benefit (now Job Seekers Allowance) when unemployed. They would be entitled to these benefits because they had paid into the National Insurance scheme and they met the life circumstances criteria – they had reached retirement age, for example. These benefits were not related to a person's income, neither were they charity – they were an entitlement. They were **universal benefits**, available

to all who had paid into the scheme and met the life circumstances criteria.

In addition to the National Insurance benefits (often called 'contributory' benefits, because they depended on payment of National Insurance contributions) there were **means-tested benefits** for people who had not paid into the scheme, normally because they had not been in consistent employment – and, of course, there would always be people who had *never* worked. Eligibility for means-tested benefits depended on people's level of income and their level of savings. Those unable to work, who had not paid into the scheme, would be entitled to benefit only if their own resources fell below a certain level – the level that the government thought adequate to keep them out of poverty. This approach, therefore drew on Rowntree's concept of a poverty line. The benefits today that are means tested include Income Support, Housing Benefit, Educational Maintenance Allowance, and the non-contributory Jobs Seekers Allowance – paid to the unemployed who have not paid sufficient contributions to the National Insurance scheme.

The take-up of benefits

Of particular interest (and concern) to social workers is why, despite poverty, a significant proportion of the benefits aimed at the poorest in society is not claimed, including benefits aimed specifically at older people. The benefits with the lowest take-up rates are the means-tested benefits. There are many possible reasons why this might be the case:

- The benefit system is very complicated, and people are often not clear of their entitlements.
- The forms that need to be completed are long and often complex.
- The questions asked and the information required can be seen as an invasion into privacy, and too much of an intrusion into personal circumstances.
- Some claimants are too proud to claim their benefit, particularly the means-tested benefits. Some older people in particular still see this as charity rather than an entitlement.

- Some people feel that there is a stigma attached to claiming their benefit.
- Claiming means-tested benefits often requires visiting the Benefits Office, and some feel that there is a stigma attached to this as well.

Poor take-up of benefits

Martha is seventy five years of age. She lives on her state retirement pension and is finding it difficult to manage. An advice worker who visited the day centre she attends explained to Martha that she could also claim Income Support and additional Housing Benefit. Both of these are means-tested benefits. Martha became quite annoyed and impatient at this advice. She said "I don't want the social prying into my private business. I haven't claimed anything in my life before and I'm not going to start now. Anyway it's so complicated. They want to know everything. And what if I get it wrong? I could be all over the newspapers if I claim too much".

In the mean time Martha is depressed and worried. She is frightened to put on the heating in the winter because she cannot afford the bills. Her diet is poor and her general quality of life declining.

Check your understanding

- 1 Define the terms 'primary poverty' and 'secondary poverty', as introduced by Seebohm Rowntree.
- 2 Explain the difference between universal benefits and means-tested benefits.
- 3 Which groups in our society are most vulnerable to poverty?
- 4 Identify the likely reasons why there is a lower take-up rate for means-tested benefits than for universal benefits.

extension activities

- 1 Using the internet, your local library, Citizen's Advice Bureau, or Benefits Office, list and briefly describe five universal benefits and five means-tested benefits.
- 2 Universal benefits are available to the most wealthy members of the community – who could quite well manage without them. Is this a good use of taxpayers' money? Discuss this with reference to Child Benefit.

Topic 7

Mental health

Getting you thinking

Your local health authority is planning to open a hostel in your area for people with mental health problems.

- 1 Write down your initial feelings about this plan.
- 2 Compare your thoughts with other people in your class
- 3 How do you think the people who live nearby will feel?
- 4 Try to identify two reasons in favour of this plan, and two reasons against it.



KEY TERMS

Institutionalisation

The process of becoming dependent on the rules and routines of large organisations.

Labelling

The process of attaching stigmatising stereotypes to particular groups of people who are then seen as all sharing negative characteristics.

Multi-disciplinary team

A team of care workers from a range of professional backgrounds. The team may include doctors, nurses, social workers and occupational therapists, for example.

Stigma

A term closely related to labelling which refers to the impact of negative attitudes and behaviour on the health and well-being of marginalised groups, e.g. offenders, the mentally ill or travelling families.

Total institution

A large, highly organised residential establishment where people live their lives completely separately from the wider society, e.g. a prison or an army barracks or a large mental hospital.

How do we measure the health of the nation?

In Unit 9 there is a fuller discussion of what we mean when we describe somebody as 'healthy'. A favoured definition by health and care workers is the World Health Organization's view that health is 'a state of complete physical, mental and social well-being, and not the absence of disease or infirmity'.

Measuring how far this has been achieved across all sections of the population, however, and how that compares with other societies and across other historical periods, is a challenge. In order to measure well-being statistically there has to be a clear definition that is, in itself, measurable – a challenge indeed.

Most research – and hence most statistical information – on the healthiness of nations describes levels of *ill-health*. There is, for example, detailed data available on the numbers of GP and hospital appointments, the take-up of immunisation programmes, the incidence of diagnosed mental illness, levels of morbidity and mortality, including suicide rates. All this data has been analysed by social class, occupation, geographical region, ethnicity, age, sex and occupation – variables that are far easier to define and measure than levels of well-being. To measure our own level of well-being is challenge enough, so comparisons with others are not easily open to objective study or statistical analysis.

What is mental illness?

Mental illness is very common (and we will discuss the statistics that support this claim later) but there is a great deal of controversy, discussion and uncertainty about what we mean by a mental illness, what are the causes and how people can be helped to recover. There are difficulties of definition. What is seen as 'normal' and 'abnormal' behaviour varies between societies, and at different times in history. Further, there can be considerable difficulties in diagnosis and appropriate support when doctors, carers and clients are from different cultural or religious backgrounds.

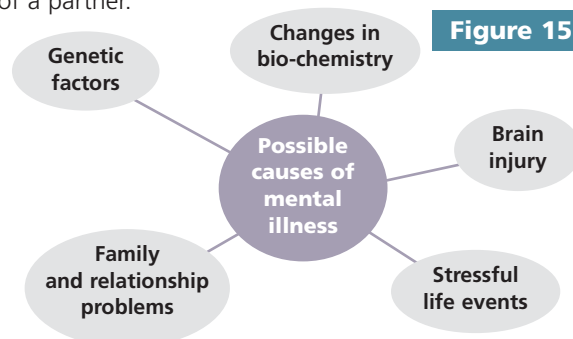
Psychiatrists have, however, categorised different forms of mental illness. Amongst the most common are depression, anxiety, panic attacks, phobias, obsessive-compulsive disorders and schizophrenia. Identifying a condition helps, of course, with decisions on forms of treatment and the ongoing care needed. Doctors, however, may disagree on the diagnosis. Giving a specific diagnosis *can* lead to some negative consequences – sometimes referred to as **labelling**.

Labelling someone as 'a depressive' can lead to this becoming the defining characteristic of that person. It is seen as their main characteristic, and other aspects of their life – as a parent, teacher, lover and friend – are overlooked. The condition becomes a label that they have great difficulty leaving behind, even when the symptoms have gone.

This lack of clear definition and certain diagnosis could be seen to underpin the ignorance, fear and anxiety about issues of mental health, and the prejudice faced by many people with mental health problems.

The causes of mental illnesses

The causes of mental illness and distress are also not fully understood. They are part of a wider discussion of the link between nature and nurture – that is, whether our personalities are shaped by our genetic make-up or the result of our life experiences. It is likely that mental distress is the result of a combination of factors drawn from our inherited characteristics (our genes), ongoing changes in our biochemistry (e.g. hormonal changes) and life experiences, including our family background and the consequences of stressful life events. It is possible that some people, because of their genetic make-up, are more vulnerable to mental illness than others, and that the illness is triggered by stressful or traumatic life events, such as divorce, redundancy or the death of a partner.



How common is mental illness?

It is very difficult to accurately calculate the levels and incidence of mental illness. There are readily available statistics on the frequency of mental health problems in the UK, but these statistics need to be treated with caution.

The number of people identified as suffering from a mental illness will often be based on the number of people presenting themselves for treatment. But there are many people with mental health problems who do not seek professional help – for a range of reasons. They may not realise that they are ill. They may

explain their feelings in all sorts of ways – ‘life can be hard’, ‘everybody feels low sometimes’, ‘perhaps this is normal’. Furthermore, attitudes to mental illness are complex, and people are often quite unwilling to accept that they or their family have a mental health problem. There is often a **stigma** linked with mental illness which doesn’t apply to people presenting with most physical conditions. This might lead to a disadvantage when applying for jobs, places on educational courses and engaging in other areas of social and economic life. Furthermore, psychiatric diagnosis is complex and often far from straightforward. Psychiatrists may differ in their diagnoses and sometimes the diagnosis may change several times in the course of treatment.

An alternative method of measuring the levels of mental illness is to conduct a ‘community survey’ – interviewing a sample of the population and, according to set criteria, identifying whether they have a mental health problem. This is seen as more reliable. The most recent and largest survey of this type was carried out in by the Office for National Statistics in 2000. This survey put the ‘prevalence’ of mental illness in Great Britain at one in six of the population. (That is, at the time of the study, one in six people had a mental health problem.) Another study by Goldberg and Huxley, which used a wider definition of mental illness, put the figure at one in four.

care – a view that has subsequently been seen to have no foundation. Good care in the community is expensive and, in fact, more expensive than institutional care. There was, however, an increasingly held view that large institutions were not providing the appropriate care for most people with mental health problems. The arguments for community care were strengthened by the writings of Erving Goffman. In his book *Asylums* (1961) he claimed that residents in large institutions – and he used mental hospitals as his main example – became so dependent on the rules and routines of these institutes that they were often unable to function independently in the community. He claimed that this process took place, not only in large mental hospitals but also in other large and socially separate institutes, which he called **total institutions**, including prisons, convents and army barracks. He called this process of increased dependency **institutionalisation**.

The vast majority of people with mental health problems today are cared for within the community. The small minority who need hospital care are increasingly cared for on a psychiatric ward of a general hospital rather than in a separate institution. Contrary to the impression sustained by sensational stories in the media, the number of mental health patients who are either a danger to themselves or to others is very few. People in this situation are cared for in hospitals under the Mental Health Act, discussed below.

The Community Mental Health team supports people and their carers who have mental health needs and are living in the community. This is staffed by a **multi-disciplinary team** consisting of health and social care staff. The team may consist of community psychiatric nurses, occupational therapists, social workers, a psychologist and counsellors. The government is encouraging closer cooperation between social services and the health services, and in some areas the health and care services are now jointly managed. The community care services will include day centres, home care workers, meals on wheels, hostels and sheltered housing projects, social clubs and befriending schemes to support people with mental health needs who are living in the community.

The law and mental health

Section 1 of the **Mental Health Act 1983** defines a mental disorder as ‘mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of the mind’.

The vast majority of people who are receiving treatment in a psychiatric unit or hospital are voluntary patients – ‘informal patients’ as defined in the Mental Health Act. They are legally free to discharge themselves from hospital and they can

The care of the mentally ill

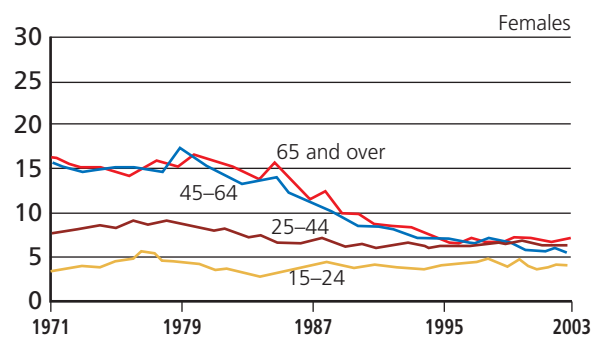
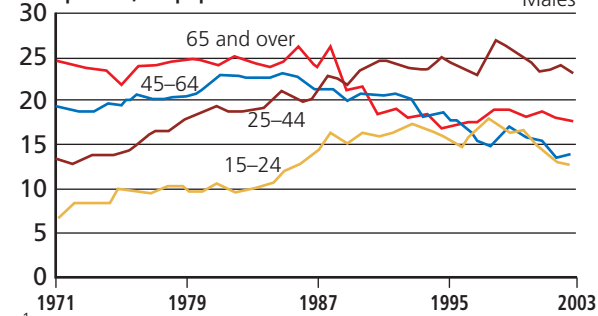
The care of people with mental health problems is the statutory responsibility of the National Health Service and the local authority social service departments. The large Victorian mental institutions (often one-time workhouses but latterly normally called psychiatric hospitals) are largely a feature of the past. ‘Community care’ as a strategy for psychiatric patients was first mentioned in the 1954–57 Royal Commission on Mental Illness and Deficiency. It was recommended that there should be a ‘general orientation away from institutional care in its present form towards community care’. There was some movement during the 1960s towards increasing care in the community. A 1975 government white paper, *Better services for the mentally ill*, recommended a move towards community care and day care provision. And this trend became a requirement following the 1990 NHS and Community Care Act.

The move towards community support rather than care in hospitals may have been seen by some as a way of saving money. It was thought that care in the community would cost significantly less than hospital

Suicide rates:¹ by sex and age

United Kingdom

Rates per 100,000 population

**Figure 16**

¹ Includes deaths with a verdict of undetermined intent (open verdicts). Rates from 2002 are coded to ICD-10. Rates are age-standardised to the European standard population.

refuse treatment. They have exactly the same rights as people in hospital with physical ailments.

Part 2 of the Act concerns 'formal patients' who constitute approximately 15% of psychiatric patients in hospitals. They are compulsorily detained under the Mental Health Act, and lose some of the rights enjoyed by informal patients and other citizens. They are not free to refuse treatment or to leave the hospital.

Mental Health Review Tribunals hear applications from patients concerning decisions by psychiatrists and other medical practitioners. The purpose of the hearings is to decide whether and under what conditions people should be discharged from hospital under Part 2 of the Mental Health Act 1983. A tribunal normally has three members – a doctor, a lawyer and a lay person, who would normally have experience in areas of mental health and social services.

The Disability Discrimination Act (1995), discussed in Topic 4, applies equally to mental health as it does to physical disability. People with mental health problems have recourse to the law – and a right to support from the Disability Rights Commission in cases of perceived discrimination in employment, in education and in access to goods and services.

Suicide

There is a statistical link between the incidence of mental illness and suicide. The suicide rate for men is some three times higher than for women, and has

increased alarmingly for young men over 15 – and particularly for men between 25 and 44.

As with all statistics, suicide statistics must be used with caution. There may be instances where a verdict of suicide is unrecorded to spare the family additional grief – or even for insurance purposes. On occasion, suicides may be recorded erroneously as 'accidents'. Overdoses of drugs, for example, may be recorded as accident. Factors that are linked with suicide include being male, living alone, being unemployed, alcohol misuse, and drug misuse.

Check your understanding

- 1** Why is it difficult to measure the level of mental illness in our society?
- 2** Identify factors that may contribute to mental illness.
- 3** What is meant by the term 'institutionalisation'?
- 4** Why has there been a movement towards community care for people with mental health problems?
- 5** Explain the difference between a 'formal' and an 'informal' patient, under the Mental Health Act 1983.

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Topic 7 Mental health

extension activities

- 1** Using the internet, your local library, and information provided by your local health and social care services, investigate the services available in your area for people with mental health problems.
- 2** A public meeting has been called to discuss the plan to build a hostel locally, for people with depressive illnesses. Working in pairs, prepare two statements – one arguing the case for the plan, and the other opposing it.

Topic 8 Ability and disability

Getting you thinking

- 1 How would you define the term 'disability'? Compare your definition with those of other people in your group.
- 2 How easy is it for a person in a wheelchair to go shopping in the High Street that you normally use?
- 3 Imagine that you needed to use a wheelchair. How easy would it be for you to attend school or college and follow this course?



KEY TERMS

Direct payments

Cash payments made to people assessed as needing community care services, so that they can select the specific support they need.

Disabling environment

An environment in which adaptations are not in place to ensure that people with impairments can take a full part in day-to-day life.

Impairment

The limitations that may be made on an individual due to physical, mental or sensory dysfunction.

Institutionalisation

The process of becoming dependent on the rules and routines of large organisations.

The difficulties of definition

As in so many areas of social care and social policy, terms relating to people with physical disabilities and impairments are used in different ways by different writers. It is important when considering these issues to be clear exactly how you are using the terms. In many ways there is no clear dividing line between people with disabilities and the rest of society. Most of us will suffer disabilities at some point in our lives, and the same condition may create serious problems in day-to-day life for some people but not for others. Some may therefore regard the condition as a disability, whilst others may not.

Accurate figures of the number of people with disabilities are not known. This is partly because of the difficulties of definition and partly because the registers of people with disabilities kept by local authorities are incomplete. There is little agreement over who should be identified as 'disabled'. In 2005, the definition used in the Disability Discrimination Act was extended to protect more people with HIV, cancer and multiple sclerosis, and the requirement that a mental illness should be clinically 'well recognised' was removed. The government is currently revising its guidance on the definition of disability.

The Disability Discrimination Act 1995 defines a person with a disability as 'someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'. 'Long-term' normally means that the effect of the impairment 'has lasted or is likely to last for at least 12 months'. Normal day-to-day activities includes things like eating, washing, walking and going shopping.

A helpful distinction can be made between the terms '**impairment**' and '**disability**'. Impairment is seen as the limitations that may be made on an individual, due to physical, mental or sensory dysfunction – with a focus on the individual. Disability, on the other hand, is seen as the restricted opportunity to take part in the normal life of the community, due to physical, social or attitudinal barriers.

The medical model of disability

Images of people with disability often show restricted mobility – people using wheelchairs, for example, or white canes. But there are many physical conditions, of course, that may be 'disabling' but are not visible – such as back pain, heart conditions or asthma. The medical model views disability as a dysfunction or an impairment located within the person's body. They have multiple sclerosis, for example, and their

Medical model of disability

Aziz became blind as an adult as a result of diabetes. He cannot read Braille. He has had very little support to develop skills for daily living. He is very nervous of using kitchen equipment and, in fact, cannot even make a cup of tea with confidence. Aziz is never sure that the house is clean and this bothers him quite a lot. Although he has a white stick to use outside Aziz is very nervous of going out of the house. The roads are very busy where he lives and the pavements are uneven. Aziz also feels personally vulnerable. He knows that anyone could take advantage of him. He's usually quite frightened when he goes out. Aziz has explained this situation to his GP. Unfortunately his GP says that Aziz just has to adapt to his new situations. He tries to impress on Aziz that he has a serious disability and that he needs to adapt his life to this.

difficulties in day-to-day living would be seen as a consequence of their condition. It would thus be seen as the individual's responsibility to adjust to the limitations that may follow.

The physical consequences of a medical condition or impairment, however, will vary. The age and personal circumstances of the person will impact on its effect, for example, and people's attitudes to the condition will affect its impact on day-to-day life.

The psychological approach to disability

The psychological approach to disability also has its main focus on the individual, with a particular concern that individuals should adjust to their condition. This approach will address the individual's mental response to their impairment and the therapy given may be concerned with developing coping strategies.

The social model of disability

In contrast to the medical and psychological models, the social model locates disability within society. If someone is in a wheelchair – but there is 100% access to all amenities – then proponents of the social model would feel that they no longer had a disability. They would have an 'impairment' but this would not impact negatively on their day-to-day life. The social model therefore locates the problems not with the individual, but in the physical environment, and in people's attitudes and practices. Here the onus is put on society to adapt to the needs of people with disabilities. The

Social model of disability

Carl, aged 25 is a solicitor's clerk who has multiple sclerosis. He can now only walk short distances. He always uses walking sticks and often a wheelchair to get around his home and workplace. His house has been adapted so that he can carry out all normal day-to-day activities. The doors have been widened for his wheelchair, the electricity points are now at waist height and he has had a stair lift, adapted bath and shower fitted. Carl's employer has also tried to help by providing him with a laptop so that he can often work from home. Carl now has an adapted car and is able to visit his family and friends quite easily as well as go on holiday and plan an active social life of his choice. He has impairments but the adaptations to his home and work environment mean that he rarely feels 'disabled'.

focus of this model is on the **disabling environment**.

It is probably more helpful to consider the valuable insights of all three models rather than to just see them as three competing ideas. It is necessary to understand the likely physical impact of a condition in order to make appropriate environmental changes and organise appropriate support. It's helpful to use the insights of psychology to support people in their adaptation to change. However, it could be argued that social care workers need to particularly embrace the social model if they are to ensure that people with impairments are going to fully participate in their communities.

Government responses to disability

The growth of separate institutions to care for people with disabilities started in the Industrial Revolution when more and more people started working away from their homes – in factories and mills. Most people with disabilities who could not be cared for at home by their family or friends lived in hospitals and other institutions – some of them one-time workhouses. This system of care had its roots in the medical model of disability. The people diagnosed as disabled were cared for by medical, nursing and care staff. They were separated from the wider society and vulnerable to the **institutionalisation** discussed in Topic 7. There was no thought that society could or should adapt so that they could be included in the social and economic life of the time. This approach persisted through much of the twentieth century.

The 1944 Disabled Persons (Employment) Act required local authorities to establish the number of people with disabilities in their area, and Part 3 of the 1948 National Assistance Act placed a duty on local authorities to arrange services for disabled people. This measure largely resulted in people going into residential care rather than living independently in the community. The 1970 Chronically Sick and Disabled Persons Act required local authorities to establish the number of people with disabilities in their area, compile a register of people with disabilities and provide for their needs. The response to this requirement, however, varied across the country. The register did not clearly guide provision, which was less than adequate – and in some areas it was ignored. Further, the services available were not well organised from the point of view of the user. There was insufficient coordination of provision, and navigating the systems was complex, and often disheartening. This legislation had attempted to address individual care needs but it did not, in itself, address the *wider issues* – access to employment, education, public services and many public buildings. The existence of the 'disabling environment' was still largely ignored. Not until the passing of the Disability Discrimination Act 1995 was there legislation that required employers, public authorities and care workers to organise and adapt their provision to meet the diverse needs of the population.

The NHS Community Care Act 1990, as its name suggests, was a key point in the development and delivery of care services outside institutions and within communities. It required local authorities to assess the

Providing services through direct payment

Mohammed is sixty-one years of age and has Parkinson's Disease. Tamsila, his wife is his main carer. Because she has arthritis, Tamsila is not very strong, finds walking painful and so she doesn't get out much. Tamsila feels pessimistic about the future and is quite depressed. Neither Mohammed nor Tamsila speaks very much English and they feel quite socially isolated.

Mohammed needs considerable help with daily living activities. He and his wife have recently been assessed by the local social services department for a range of community care services. They are going to receive a direct payment for these services so that they can choose their own care providers and pay them directly. Tamsila would like to use people from the Mosque whom she knows and with whom she feels comfortable.

needs of people requesting community care services – and money was made available to the local authorities to finance the provision. At the same time, the larger institutions were closing. Community care provision could include social work support, home care workers providing practical support with daily living activities, day centres providing social, educational, recreational and other therapeutic activities, and physical adaptations to living accommodation. In complex cases, the 1990 Act requires the appointment of a ‘care manager’ to plan, monitor and review the provision for users and their carers. In 1995, the Carers (Recognition of Services) Act gave informal carers – usually unpaid family and friends – the right to a separate assessment of their needs too.

The 1996 Community Care (Direct Payments) Act allowed local authorities to make cash payments to people who have been assessed as needing community care services. This has been in part a response to the view that people with disabilities should make their own decisions about how their care needs are met, who provides them and how the services are delivered. They use their cash payment to pay for their chosen services.

It was not until the passing of the Disability Discrimination Act (1995) that there was a shift in policy towards ‘rights’ for disabled people. The Act gives disabled people rights in the areas of:

- Employment
- Access to goods, facilities and services

- Buying or renting land or property.

The proposed Commission for Equality and Human Rights, discussed in more detail in Topic 4, is expected to replace the Disability Rights Commission in 2007. It is expected that the work carried out by the Disability Rights Commission will continue through the new combined commission.

Check your understanding

- 1** How does the Disability Discrimination Act define ‘disability’?
- 2** Define the term ‘impairment’.
- 3** Describe the three main models of disability – the medical model, the psychological model, and the social model.
- 4** During the twentieth century, why might people with disabilities have become institutionalised?
- 5** Briefly describe the measures introduced by the NHS and Community Care Act 1990.
- 6** In what areas of economic and social life did the Disability Discrimination Act 1995 give people rights?

extension activities

- 1** Using your local library, advice bureau or social services department, research the range of community care services in your area for people with disabilities.
- 2** Using the internet, find four groups that support people with disabilities and summarise their aims and activities.