In this chapter, I will explore the relationship between UK social policy and the experience of disability. From the outset, I must make it clear that when I refer to disability, I am not talking about an embodied condition or characteristic. Instead, I use the word to refer to an oppressive social relationship experienced by people with physical, sensory, emotional, and cognitive impairments in their encounters with the physical and social environments in which they live. In other words, I am going to explore the relationship between UK social policy and disability as a social construct. I will consider the emergence of disability as a result of processes involving the industrialisation and modernisation of society during the nineteenth and twentieth centuries, and in relation to the ways in which social policy emerged to support the social changes required in the management of industrialised capitalism. I will examine ways in which, rather than being necessarily benign – being about the support of those unable to support themselves – social policy relating to disability can be viewed as part of a wider network of mechanisms used by governments to maintain structural relationships rooted in, and requiring, inequality as a principle of social organisation.

It will help to establish what I mean by the two key terms this chapter considers: social policy and disability. Dean (2012:1) has identified the term social policy as involving ‘the study of relations necessary for human wellbeing and the systems by which wellbeing may be promoted or, for that matter, impaired’. Key to this definition are two distinctions. Social policy may be regarded as an academic discipline, as a way of thinking about and looking at the processes by which arrangements for the delivery of welfare are planned, delivered, and received, by whom and for whom. But it also involves these processes themselves, the laws and policies that are put in place to make these things happen, the thinking behind them and thinking about where this thinking has emerged from. A traditional view would state that social policy deals with things like health, education, income maintenance, housing, and personal social services, and impacts on all our lives throughout our lives: from providing a basic level of health care, child benefits and tax credits to compulsory school education when we are infants and children; to providing higher education, guaranteeing a minimum wage, ensuring minimum standards for services we use, and financial support in times of unemployment and hardship when we are adults; to providing a state pension and personal care in old age (Seeley, 2015). It is also, however, wider than this in its significance. Social policy reflects and enables social change, influences the way we communicate with each other, the way we see each other, and gets to the core of our identities: whether we regard ourselves primarily as citizens or as consumers (Cahill, 1994). By regulating the things we are obliged to do and the things we are allowed to do, it shapes the way we act in the world.

It must be remembered that social policy does not just emerge in a vacuum (Dean, 2012). It is not something imposed on society from outside, but is to do with the way society maintains and organizes itself. Those who shape social policy do not do so from some outside vantage point, but as members of society themselves. Social policy is always shaped by the concerns, ideas and material conditions amidst which policy makers find themselves. It draws on prevailing discourses and available narratives. Because it builds on previous legislation and policy in a piecemeal way, attempting to address current concerns through continuous reform of the existing system, it is important to keep in mind that – for all it is the handmaiden of social change - it has a past and that this past continues to make itself felt in the present. In that it constructs roles and identities for
different social groups – children, older people, women, students, workers, unemployed people, members of ethnic minorities, disabled people, for example – there is a requirement for social policy to be approached with a critical view. It is necessary to understand that things are as they are not because that is how they just happen to be, or because this is the natural way for them to be, but that existing social arrangements reflect particular historical perspectives and the interests of particular social groups. It is necessary to remember the role of social construction in the way we perceive and relate to difference. Not only is our sense of who we are determined by the social and historical contexts in which we live, but the way we are able to make meaning of the situations with which we are confronted.

If we consider Dean’s definition of social policy again, from a critical perspective (as Dean himself does), we find ourselves asking questions of it. To state that social policy involves ‘the study of relations necessary for human wellbeing and the systems by which wellbeing may be promoted or, for that matter, impaired’ involves making a number of assumptions. Central here is the view that human wellbeing is the object of social policy. This in itself, however, can be regarded as a controversial claim, which will be examined in this consideration of social policy and disability.

Defining disability is also a contentious issue, depending on the position we take. There are two fundamentally opposed approaches to identifying disability, known as the medical and social models (Drake, 1999:14). The term ‘models’ is used to describe ‘frameworks which not only structure the thoughts, ideas and concepts we hold in our heads and give order to what we know (or think we know) about the world, but also suggest ways of acting upon the world’ (Cameron, 2015:111). The medical model is the dominant model within contemporary society, reflecting a view of disability that has been developed by non-disabled people, and is expressed most clearly in the World Health Organisation’s 1980 International Classification of Impairments, Disabilities and Handicaps (ICIDH). This defines disability as:

any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

(WHO 1980, in Barnes and Mercer, 2010:20)

Within this definition, disability is identified as an individual problem, the direct result of impairment, and has to do with the way some people’s bodies are made, shaped or experienced, insofar as they differ from the way the majority of bodies are made, shaped and experienced. Two points require emphasis here. Firstly, in using terms such as restriction or lack of ability, disability is first of all problematized, regarded only as something that can only be understood negatively. Secondly, it is identified as an individual problem, suggesting that the resolution to the problem lies in changing the individual. Such individualising descriptions can also be found in WHO’s more recent definitions which identify ‘disabilities’ as impairments, activity limitations and participation restrictions (WHO, 2012, in Mallet and Slater).

The social model, which has been developed by disabled people themselves, offers a different view, defining disability as:

the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them from the mainstream of social activities

(UPIAS, 1976, in Cameron, 2014).

Within this view, the focus of the problem is shifted from the bodies of individuals to the way that society is organised. Disability is not regarded here as to do with bodies identified as abnormal, but
to do with society’s unwillingness to value and include difference. Relating this to social policy, Roulstone and Prideaux (2012:3) have commented that:

By definition, to have been disabled for much of (the last 200 years) is to have failed to have lived up to standards or stereotypes of what are held to be ‘normal’ measures of success, with containment and segregation a key impulse behind disability provision.

In arguing from a social model perspective in this chapter, my aim is to make it clear that the relationship between disabled people and social policy has not always been a very positive one. Further than this, I would suggest that social policy has played a major part in the construction of disability as deficit, and that there has been a structural purpose served by this construction. What I am suggesting is that much of the disadvantage experienced by disabled people is not the natural outcome of the experience of impairment, but the outcome of the way that – through the policies, systems and services which have emerged - society has decided to deal with people with impairments.

Hahn (1985:294) has argued that ‘Fundamentally, disability is defined by public policy. In other words, disability is whatever policy says it is.’ Here Hahn makes the point that, rather than being some natural, unchanging fact, which will be experienced in much the same way across very different social and historical contexts, what we understand by the word disability is subject to change and vacillation according to what we are told it means. The 2010 Equality Act, for example, identifies someone as disabled ‘if you have a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on your ability to do normal daily activities’ (Gov.UK: undated). This is a medical model definition in that it identifies being disabled as the direct outcome of being impaired and as a limiting characteristic of individuals. This definition is regarded as carrying authority because it is enshrined in law, however, and is taken as having common sense, obvious validity. What is paradoxical is that it is enshrined in a law that has been established with an ostensibly benign aim: that of protecting disabled people, among others, from discrimination. It establishes disability as an unfortunate and negative experience and at the same time establishes legal codes to prevent people from treating disabled people unequally. This meaning is conveyed to both disabled and non-disabled people. As part of a dominant disability discourse, it ‘both opens up and closes down possibilities for action; it constitutes ways of acting in the world at the same time as it posits a description of it’ (Abberley, 2002:122). If we believe that disability is an individual problem, signifying limitation, misfortune and negative experience, this will influence the way we relate to and respond to the appearance of what we name disability, both at social and individual levels. As Oliver and Barnes (2012:14) remark:

If we define situations as real, they are real in their consequences... As far as disability is concerned, if it is seen as a tragedy then disabled people will be treated as if they are the victims of some tragic happening or circumstance.

I would argue that this contemporary paradox is largely the outcome of a line of thinking about disability which can be strongly associated with the development of social policy in industrialised capitalism.

Barton (2001:169) has pointed out that ‘insofar as disability thought of socially, culturally, or historically, it is usually represented in terms of improvement’. The days of long-stay, remote institutions are past, disabled children often now receive school education alongside their non-disabled peers, and high street shops, restaurants and places of leisure are commonly more accessible than they were a couple of decades ago. However, Barton continues:
I would argue that disability also must be defined as a more complex social construct, one which reflects not a benign evolution of acceptance but a dynamic set of representations that are deeply embedded in historical and cultural contexts (Barton, 2001:169).

While undoubtedly the last few decades may have seen progress in some areas, disabled people are still significantly more likely to be unemployed than non-disabled people; more likely to hold fewer educational qualifications; more likely to experience unfair treatment at work; more likely to live in poverty; more likely to live in unsuitable housing; more likely to find it difficult to access public transport; and significantly less likely to participate in cultural, leisure or sporting activities (DWP, 2014). There has been recent controversy about the large numbers of disabled people who have died shortly after the termination of their claim for employment and support allowance following a finding by a work capability assessment that they were fit for work (DWP, 2015). There is great concern and active organisation against the possibility of the legalization of assisted suicide because of well-founded arguments that this will lead to pressure on many disabled people to end their lives. Parents of unborn children identified through pre-natal screening as impaired are routinely expected to terminate pregnancies. There is increasing recording of hate crime against disabled people. The story of disability is, then, hardly one of ever-widening emancipation and acceptance. Rather, it is one of contradiction.

Medical model thinking has its origins in the processes of industrialisation which transformed British society during the eighteenth and nineteenth centuries and in the social policy measures which emerged both as a response to, and as a means of trying to manage this transformation. While there is much evidence that people with impairments have been on the receiving end of prejudice throughout the history of western civilisation (Barnes, 1997), there is a consensus among Disability Studies theorists that ‘prior to the Industrial Revolution of the late eighteenth century, disabled people were part of an undifferentiated mass poor, and hence clustered at the lower reaches of society, but not excluded from it’ (Borsay, 2002:103). The Poor Law of 1601 recognised people whose impairments meant they were unable to work as deserving of ‘outdoor relief’ in terms of financial or in kind support from local Poor Law guardians. Roulstone and Prideaux (2012:4), for example, note that:

The recognition of the unmet needs of sick, infirm and disabled people, although very basic and locally haphazard, did afford basic protection for disabled people to at least survive among their non-disabled counterparts.

Impairment was commonplace, regarded as inevitable and ordinary rather than as something separate from everyday life or that required to be normalised. The shift in the circumstances of people with impairments came with the emergence of the factory system of production, the establishment of new production norms, and the requirement for an army of able-bodied workers who could operate the new machines which would generate profit for capitalist manufacturers. The appearance of normality as a principle underpinning social organisation coincided with the struggle during the nineteenth century to find ways of controlling the rapidly increasing scale of human movement that accompanied industrialisation (Garland-Thomson, 2009). The word ‘normal’, as used to mean ‘conforming to, not deviating or differing from, the common type, standard, regular, usual’, only enters the English language around 1840 (Davis, 1995:24).

The Poor Law Amendment Act 1834, which has been identified by many as the first modern piece of social policy legislation, had as its object the assurance of the operation of a ‘free’ labour market ‘by ensuring that all who were sane and able-bodied should work – never mind where or upon what terms such work might be found’ (Dean, 2012:18). A distinction was made between ‘the deserving’ and ‘the undeserving’ poor, with relief being dependent upon admission to one of
the newly built local workhouses. Conditions within these workhouses were made as miserable as possible, a deliberate policy intended to deter any from seeking public support and to ensure that this would always be regarded as a last option. Moral values of self-sufficiency and industriousness were preached, exhorted and inculcated through the Church and through popular culture, exemplified by Samuel Smiles’ 1859 book *Self Help*. People with impairments, identified as idiots, lunatics and cripples, found themselves herded into asylums and workhouses where they first came under the gaze of medical professionals who saw it as their task to cure or restore these inmates to health (Barnes, 1997). From a social model perspective, it was this historic removal from society that established disablement and stigmatised and medicalised impairment (Oliver and Barnes, 2012). A role was created for disabled people as objects of pity and horror. A terror of the same fate became a concern of the able-bodied. To be in want of charity became regarded as a mark of shame and personal inadequacy. Dickens’ character Betty Higden in *Our Mutual Friend* depicts this well.

At the same time the migration of labour from the land to the expanding centres of production, the towns and cities, led to chronic overcrowding as huge numbers of people lived in closer proximity to each other than ever before. As Dean (2012) has noted, social policy measures in terms of public health and factory legislation were introduced to safeguard the health of the industrial middle class and to maximise the efficiency of industrial production. Accompanying new social policy measures there was a requirement for individuals to focus increasingly on continuous self-monitoring and the exercise of bodily self-control in every respect. Ferguson has remarked that:

> appropriate dress, appearance, polite modes of eating and drinking, acceptable means of coughing, sneezing, urination and defecation, the proper restraint in gesture and forms of interaction, and the provision and protection of personal space all featured in the new corporeal pedagogy (Ferguson, 2006:106).

Economic survival in industrialised Victorian Britain required ever closer self-surveillance and attention to the presentation of self as normal. The introduction of compulsory elementary education after 1870 was ‘not so much for the benefit of the working classes as to fit them for the requirements of the new economic and social order’ (Dean, 2012:18). School education was primarily a disciplinary process through which children could be transformed into ‘docile bodies’ (Foucault, 1984), and learn how to become the people they were required to be: the next generation of labourers, producers and reproducers within capitalism. The Elementary Education (Blind and Deaf Children) Act 1893, was premised on the assumption that disabled children would be educated separately from non-disabled children. The impact of early social policy, then, in relation to disability, is to wedge an increasing distance between disabled and non-disabled people. When conformity to the requirements of industrial society is required, the normal self-consciousness must be that of:

> people who have been compelled to adopt a very high degree of restraint, affect, control, renunciation and transformation of instinct, and who are accustomed to relegating a large number of functions, instinct-expressions and wishes to private enclaves of secrecy withdrawn from the gaze of the ‘outside world (Elias, 2001:28).

The uncivilised, rebellious bodies of the impaired were removed from the public sphere because they acted as a reminder of the indiscipline of the natural body, an unsettling threat that might undermine perceptions about the naturalness of the new social order. At the same time, within the institutions they had been removed to, disabled people were made to understand the ugliness and wrongness of their own embodied physicality. They learned that the only hope for anything better in life was dependent on becoming more like ‘normal’ people.
The Liberal Reforms made between 1906 and 1911 widened the sphere of government intervention to include areas including housing, health and social services that had not previously been considered its responsibility. They broadened its role in others by introducing national pensions and extending government’s involvement in the administration of education (Seeley, 2015). Rather than being the outcome of a humanitarian interest in the welfare of its citizens, however, these reforms were made in response to the discovery during the Boer War of the extent of unfitness and ill health among recruits (Alcock, 2008). They were not so much about the welfare of individuals as about ensuring the defence of the interests of capital against external threat.

Many of the architects of emerging social policy were strongly committed Eugenicsists. Eugenicsists applied Darwin’s theory of natural selection to human beings, arguing that while those with strong, healthy genes should be encouraged to breed and extend the population, others with unhealthy genes should be strongly discouraged from reproducing. Social problems including crime, vagrancy, alcoholism, prostitution and unemployment were linked with physical and intellectual impairment (Brignell, 2010). Eugenicsists questioned the idea of providing medical support and social services to disabled people, arguing that this would enable those to survive who were not meant to survive and lead to the degeneration of the national gene stock. In 1903 Parliament established a committee on ‘national deterioration’ and set up the Eugenics Record Office in London. The 1913 Mental Deficiency Act introduced IQ tests to identify ‘feeble-minded’ children who were sent to segregated schools (Burdett, 2014). Key left wing thinkers prominent in the development of social policy, including the founders of the Fabian Society, Beatrice and Sidney Webb, and the architects of the post-1945 British welfare state, William Beveridge and John Maynard Keynes, were fervent advocates of eugenics. As Beresford (2016:142) has noted:

many social reformers are better understood as committed to moral and utilitarian rather than humanistic concerns... Interest was less to do with the personal welfare of the people and groups involved and more to do with what they saw as the ugliness, inefficiency, immorality, evil and wider damage that they associated with them.

Fabianism, which became the dominant strand in the study of social policy in the early 20th Century, was characterized by a reformist approach, seeking ‘change within the system rather than a change of systems’ (Walker, 2015:39). It supported the ideas of state intervention and the planned redistribution of resources, but involved a very elitist, ‘top-down’ approach (Croft and Beresford, 1992). This is to say that it was identified as being the province of ‘experts’ to identify, investigate, research and prescribe resolutions to what they defined as ‘social problems’. One limitation of this approach was that, for all its stated technical objectivity, it involved social policy experts in drawing upon existing constructions and perceptions which had evolved within a specific historical context. It has been identified as problematic in that it regarded the development of policy as administrative rather than political, and overlooked the exercise of power in its prognostications. There has been a problematic history within social policy that has involved experts identifying their own solutions to people’s problems and imposing them on them, rather than listening to people’s views about themselves and their own experiences (Dean, 2007). As Walker (2011:40) points out, the constructions informing social policy do not stand in isolation: ‘They do not arise spontaneously nor are they sustained ‘naturally’. They are linked to wider ideologies and as such can be seen to support different and competing interests.’ The development of disability policy has been based on
problematic historical constructions involving the medicalization of disabled people and their being viewed through the prism of Eugenics.

In constructing the social contexts in which disability was experienced, policy experts have played a major role in the construction of disability itself. A policy history involving the medicalization and containment of disabled people has involved the establishment of an oppressive social relationship in which public responses to people with impairments have usually involved a mixture of fear, contempt and pity. The large scale institutionalisation of disabled people, and the restriction of opportunities to participate in ordinary community life, has led to the construction of a dependency culture and the association of disabled people with vulnerability. Albrecht (1992) coined the term ‘the disability business’ to describe the industry of professionals and other workers which developed to manage the twilight world on the margins of society where disabled people were expected to see out their lives. As Oliver (1996:37) has stated:

Further, the medical profession, because of its power and dominance, has spawned a whole range of pseudo-professions in its own image; physiotherapy, occupational therapy, speech therapy, clinical psychology; each one geared to the same aim – the restoration of normality. And each one of these pseudo-professions develops its own knowledge base and set of skills to facilitate this. They organize their interventions and intrusions into disabled people’s lives on the basis of discreet and limited knowledge and skills.

In other words, there are a lot of vested interests involved in maintaining a view of disability as a medical issue rather than as a rights issue. It is not that these are bad people, simply that, as Young puts it:

The conscious actions of many individuals daily contribute to maintaining and reproducing oppression, but these people are usually simply doing their jobs or living their lives and do not understand themselves as agents of oppression (Young, 1990:42).

Abberley (2002:132) has argued that, while the expansion of the post-1945 British welfare state was the outcome of working class strength, it retained a controlling function. ‘The dual function of the welfare state, which takes place within a set of class (and other)forces continuously in struggle, consists in services provided with an inextricably dominating character and function.’ This domination is to be found in the unequal power relationships between professionals, who had the authority to define situations as real, and service users. The welfare state was also characterized by values of paternalism which failed to recognize disability as a rights issue, instead identifying it primarily as an issue of individual need (Oliver, 1996). The compensatory welfare approach within the welfare state, which included compensatory benefits schemes and specialist domiciliary and residential care services for disabled people, still rested on the assumption that disability was to be addressed as personal deficit. As Dean (2012:88) notes, ‘compensatory approaches tend to perpetuate and consolidate rather than confront the implications of difference’. Starting from a position that the non-disabled view represented a universal norm, disabled people were inevitably found wanting.

The 1960s was a period of social change during which different social groups including feminists and the Black civil rights movement staked claims for equality and recognition on their own terms. This decade also saw the beginnings of the disabled people’s movement in terms, for example, of the publication of Stigma. This was a book of essays about disability written by disabled people and
edited by Paul Hunt, a disabled man who, on the basis of his own experiences in a residential home run by the Leonard Cheshire Foundation, had begun to develop an understanding of disability as social oppression:

We are challenging society to take account of us, to listen to what we have to say, to acknowledge us as an integral part of society itself. We do not want ourselves, or anyone else, treated as second-class citizens and put away out of sight and mind. Many of us are just beginning to refuse to be put away, to insist that we are part of life too (Hunt, 1966:138).

Hunt’s activism led to the establishment of the Union of the Physically Impaired Against Segregation (UPIAS), a forum for debate about disability issues by disabled people living in residential homes. UPIAS first set out the definitions of the social model in a 1976 publication, *Fundamental Principles of Disability*, and this was taken up as the big idea that underpinned a rapidly growing movement of disabled people which organized and campaigned both locally and nationally (Cameron, 2014[b]). A major focus of the disabled people’s movement during the 1980s and 90s was the campaign for anti-discrimination legislation which eventually led, in 1995 and after much resistance from the Conservative Government of the time, to the passing of the Disability Discrimination Act (DDA). The DDA, however, was greeted with less than enthusiasm by many of the disabled people who had campaigned for it and was renamed the Doesn’t Do Anything Act (Swain, French and Cameron, 2003). Although it provided the first anti-discrimination legislation in relation to disability in Britain, it did not amount to civil rights legislation. It was weak legislation, containing numerous exemptions and loopholes, failed to include key areas that had been called for, and failed to define such key terms as ‘reasonable adjustments’, giving employers and service providers room to dispute their responsibilities. Finally, and significantly, it retained the medical model definition of disability that has passed into the 2010 Equality Act by which it was later superseded.

As Dean (2012:83) has noted:

Equal opportunities approaches can fail to address the fundamental causes of disadvantage and underlying relations of power. They work from the implicit premise that it is discriminatory attitudes and prejudices that are the problem. It is a premise that neglects the extent to which attitudes are no more and no less than reflections or consequences of the institutional processes by which differences are socially constituted.

In terms of social policy, neither compensatory provision nor equal opportunities legislation, such as the DDA and the Equality Act, have successfully addressed the inequality and oppression experienced by disabled people, and it is unlikely they ever will. The most that current legislation will do is slightly modify some existing arrangements and leave others untouched. Capitalism is an economic system that requires competition between individuals and is organized to produce an unequal distribution of wealth and resources. There are incentives to conform and cautionary examples of what happens to those who fail to conform. People with impairments find themselves placed in a personal and social role which simultaneously invalidates their subject position as people with impairments and validates the subject position of those identified as normal (Cameron, 2014[c]). Current social policy measures in terms of welfare to work programmes have disciplinary and punitive functions compelling disabled people to conform to work practices incompatible with their impairments (Harrison and Hemingway, 2016). Capitalism is a system that works not for the benefit of its citizens, but for its own benefit and for the benefit of a relatively small number of very
rich people. Disability is an oppressive relationship experienced by people with impairments and is one of many sets of arrangements by which poverty is managed. Jones and Novak (2014:2) have stated that:

The management of poverty and inequality in the attempt to prevent it from becoming an explosive challenge to the system has for long depended on keeping the gaze of the majority downwards; so that people compare themselves and their fortunes with those beneath them rather than those above.

Rather than being a benign endeavour the object of which is the promotion of human wellbeing, I suggest that social policy is a political tool which is key to this management. Disability is the ontological and experiential price paid by people with impairments for the stabilization of one part of the capitalist structure. What is required is structures that serve people, not people that serve structures. Perhaps it would be fitting to finish with some more of Paul Hunt’s words:

Illness and impairment are facts of existence, diminishment and death are there to be thought about and taken account of in any realistic view of the world. We are perhaps also saying that society is itself sick if it can’t face our sickness.

(Hunt, 1966:158)

References


