

# 1. Disability and Social Policy

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## Introduction

Disability policy is changing. During the course of eight months between November 1989 and June 1990, the government published three major policy documents and proposed a number of far-reaching measures affecting the economic and social welfare of disabled people. The social security White Paper *The Way Ahead* (DSS, 1990) proposed the extension of benefits to meet the extra costs of disability and an allowance to be paid to disabled people in low-paid work. Recommendations in the Department of Health document *Caring for People* (Department of Health, 1989) focussed on procedures for assessing the social care needs of disabled people and the development of care packages set against the background of local authorities' limited resources. Measures proposed in the Consultative Document *Employment and Training for People with Disabilities* (Employment Department, 1990) were concerned with developing the role of voluntary and private agencies in training and rehabilitation.

Disabled people have had mixed reactions to the changes, partly because many of them dispute the fundamental premises upon which the policies are based and partly because, even within the terms of the policies themselves, disabled people believe the government is unwilling to back its measures with adequate resources. There is a growing debate within the disability movement: should social policy be concerned with enabling disabled people to fit more easily into the world as it is or should the world be altered to take account of disabled people's needs? The movement itself – organisations of, and for, disabled people – divides between reformers, who challenge the status

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quo by arguing for incremental policy improvements, and radicals, who sometimes advocate direct action in favour of fundamental change. These differences underlie many of the critiques of current policies which have been produced and thus account for the variation in approach.

The chapters in this book reflect some of these competing views. Some have been written by academic researchers, writing from a social policy perspective. Others, however, have been written from within the heart of the disability movement. Some argue for improvements or modifications in what central government has proposed, accepting those proposals as a way of beginning the discussion. Other chapters, though, are polemical and strongly dispute the presumption of any starting point in common. There is, therefore, a lack of consensus across the range of contributions. The chapters have been grouped around the themes of income and costs, care and services, and access to employment (in line with the three policy documents). This first, introductory, chapter sets out to provide some basic information about the prevalence of disability and about current and proposed policies relating to social security, social and community care services and employment. It begins, however, by discussing concepts of disability since differences of opinion at this basic definitional level are frequently the cause of major disputes about appropriate policy strategies.

### **The power of definitions**

Although there may be major disagreements within the disability movement between reformers and radicals, both would argue that they base their views on a social model of disability which contrasts sharply with the way in which society in general views disability at present. This view starts from able-bodied people's definitions of what constitutes the normal world and from their explanations of the situation of disabled people within it. These explanations are based on a medical and individual model of disability: disability is defined against narrow medical criteria upon which the classification of impairment for administrative purposes can then be constructed. The power to make decisions about the fate of the disabled person thus comes to be placed in the hands of a series of professionals – doctors, teachers, social workers, social security officers – who dispose of their charges as they see fit. Further, this model of disability is placed

within a framework of 'personal tragedy theory' whereby the experience of disability is fragmented into a series of individualised episodes devoid of sociological significance. Accordingly, disability becomes unique for each individual; the disabled person must make his/her own adjustment to the circumstances of disablement and negotiate a means of 'coping' as best s/he can.

Many in the disability movement would argue that these explanations and solutions are false (Oliver, 1990). They point in contrast to the constraints and barriers thrown up by society as the cause of disabled people's difficulties. Thus the person in a wheel-chair is disabled by society's refusal to provide accessible public transport and a blind person is disabled because no thought is given to providing alternatives to the usual, visual, means of communication and information upon which sighted people depend. By locating the 'problem' of disability within the individual, society denies any social responsibility to cater for the diversity of its citizens' needs. Disabled people are then herded together into a common category and cut off from mainstream society, dependent on the whim of the majority as to whether they are offered 'special' services or not, and denied the opportunity of having a say in what support or assistance they might prefer.

While there may be agreement within the disability movement thus far, differences emerge between radicals and reformers. Radicals stress the excluding role of a disabling society and resist attempts to see individuals' physical and mental impairments as disabling in themselves. Reformers on the other hand are more ready to accept that such impairments may be problems in their own right (although society compounds them) and that this fact provides reason enough for them to struggle to improve the social and economic conditions under which they have to live.

They also recognise that impairment, as it affects individuals, may not have uniform consequences. Thus there may be a difference between impairment which results in varying degrees of functional limitation (which may be accommodated with technical assistance) and that which creates dependency on other people to a greater or lesser degree and which cannot be compensated for sufficiently through technical aids. Where dependency on other people results, a variety of social relationships are established in which the person with impairment cannot act autonomously. How these are negotiated and

agreed (or not) creates a set of complex and sensitive factors in the individual's experience of disability. And in terms of society's disabling role, there may be a significant difference between, for example, environmental constraints which limit physical access to areas of social and working life and attitudinal and ideological prejudices which render disabled people as 'non-people' in terms of social roles and relationships.

But it is clear that the finer distinctions within the general category of 'impairment' (the condition) raise important questions about how disability (the concept) is treated. It is beyond dispute that individuals, in practical terms, are affected by different sorts and degrees of impairment. Because of this, the way in which an individual's impairment is classified has come to be used as a measure for regulating access to income maintenance benefits, employment and personal social services. Thus an individual's capacity to play a part in society is influenced not only by his or her impairment as such, but also by society's methods of classification. Not surprisingly, some disabled people object to 'severity of impairment' being used as a means of regulating access to social support; they argue that it affects their aspirations and their life chances in an unjustifiable way.

Although some disabled people, notably the radicals, may declare they do not want care (see Richard Wood's paper in this volume), others disagree. The population of those with impairments is heterogeneous; very elderly people (many of whom have severe functional limitations) may accept a reduced level of social and economic activity, while positively wishing for care and services of the sort rejected by others (Dalley, 1988). Similarly, those unable to articulate their aspirations themselves may have to depend on advocates to do so for them. Their requirement or need for care (care being the partner of dependency) rather than support may be overwhelming.

More issues arise: is there a valid distinction to be made between impairment (or disability – it is hard not to use the two terms inter-changeably) and infirmity and chronic sickness? It might be argued that disability in old age is better regarded as infirmity and frailty because elderly people do not seek to participate in society on the same terms as young (pre-retired) able-bodied people. But how can disability carried from youth into old age then be classified? Must there be two categories of elderly people – the elderly with disabilities

and the frail and infirm elderly? Can distinctions be made between care, assistance and support?

Those who reject the need for care prefer the term 'personal support' because it is neutral and does not carry overtones of dependency with it. Is the term 'dependency' useful, or is it too imbued with the normative assumptions which able-bodied people hold about those with disabilities? But while a young disabled person who seeks to function in society on the same terms as a young able-bodied person demands personal support and rejects notions of dependency, an infirm elderly person recognising his or her dependency calls out for care.

This segmentation of the disabled population raises both theoretical and practical questions. How far, in the light of the preceding discussion, is it valid to treat disability as a single conceptual category (while accepting descriptive distinctions within it)? If the presence of a disability over-rides all other attributes, then perhaps it is; but we have already noted that severity of impairment raises many difficulties – at what point does the cross-over take place from being an individual with impairment which limits function somewhat (but does not over-ride other attributes) to one whose impairment limits functioning to the extent that other attributes are severely overshadowed? And even where impairment is severe, attributes such as age and gender are likely to remain significant. To regard disability as the dominating category may mask too many important distinctions.

For those who argue that it is society that disables, these classificatory refinements may be unimportant. Nevertheless, as things stand, unless they are suggesting that society disables everyone, the fact of impairment (and its severity) does inevitably act as the trigger for society's punitive treatment. And indeed, that treatment may be unequal in its effect – with some of the inequality, at least, being related to the divisive classifications described earlier. Consideration of these issues leads directly into the politics of disability, focussing on the oppositional relationship between the 'reformers' and the 'radicals'. The first see action on disability as primarily concerned with ameliorating the circumstances of disabled people through 'compensatory mechanisms' such as income maintenance benefits, employment quotas and personal social services. The latter, seeing the social world as the force which disables people, seek to change that world rather than fight for improvements

within an unchanging wider environment – ‘prison’ as they would call it.

To a certain extent, the debate about disability is trapped in the forms of language used to describe it. The choice of particular descriptive terms reflect implicit, and sometimes changing, attitudes and assumptions about the social, psychological and political nature of disability. Terms in common usage in one generation may no longer be acceptable a few decades later. ‘Cripples’ of a hundred years ago are ‘people with disabilities’ today. Change may be gradual – brought about by real shifts in the attitudes at play in wider society; or it may be consciously constructed – introduced by the campaigning of those within the disability movement to match their own conceptions and with the intention of changing general attitudes.

Some campaigners have argued that the old terminology concentrated on the impairments rather than on the individuals affected by them. Changed terminology focusses instead on the commonality of the human condition and not the impairment. But others argue that much of the new terminology is still essentially descriptive. The radical critique of terminology goes further, matching the proposition described earlier that society disables people – thus people may have ‘impairments’ (the physical or mental condition) but they are disabled by the constraints which society imposes on them. Accordingly, they favour the term ‘disabled people’: their impairments are regarded as limitations on their physical (or mental) functioning and they are only then disabled if society imposes constraints upon their social functioning.

In terms of political action, the reformers focus on improving current policies and introducing new ones which are based on ‘realistic’ appraisals of what may or may not be possible. They tend to adopt strategies of persuasion through lobbying, campaigning and research. They rely on the empirical evidence of their own research findings and the persuasive power of describing the experience of disability as it affects individuals. Radicals, because they stress the need for fundamental change on a society-wide basis, have a much less detailed programme of action. While stressing the importance of disabled people having the power of choice and decision-making vested in themselves, they leave open what precisely ought to be done. Accepting that changes in the legal framework protecting the rights of citizens may offer some way forward, they support moves to introduce

anti-discrimination legislation but fail, on the whole, to propose any other detailed plans.

As for the policy makers, their goal seems to be a pragmatic balance between that which is preferable (gauged by listening mostly to the reformers and less to the radicals) and that which is feasible (determined by the budgetary constraints imposed by any government). They may recognise that the support from the state available at any given time is a rag-bag of policies and practices inherited from the past, often inconsistent and incoherent, but they will also argue that this is the best way to advance the cause of the people they seek to assist. The seizing of opportunities on a quiet, incremental basis avoids the stagnation that ideological confrontation would otherwise involve.

### **The prevalence of disability: the OPCS survey**

The extent of disability is hard to assess partly because of its diversity and the resulting difficulties of classification and partly because people have mixed views about defining themselves as 'disabled'. In order to come to some view of the prevalence of disability, however, the Office of Population Censuses and Surveys (OPCS) interviewed 14,000 adults with disabilities and the parents of 1,300 disabled children in 1985 and 1986. The wider survey comprised five separate surveys, and a series of reports on each of these was published in 1988 and 1989 (Martin, Meltzer and Elliott, 1988; Martin and White, 1988; Bone and Meltzer, 1989; Martin, White and Meltzer, 1989; Smyth and Robus, 1989; Meltzer, Smyth and Robus, 1989). They estimated that there were 6,560,000 people with disabilities in Great Britain in 1985. The researchers established a scale of severity of disability (OPCS used the term disability rather than impairment) ranging from one (lowest) to ten (highest). The numbers of people in each category were as follows:

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		Number in this category	Total in this category or worse
High	10	240,000	240,000
	9	390,000	630,000
	8	430,000	1,060,000
	7	530,000	1,590,000
	6	580,000	2,170,000
	5	750,000	2,920,000
	4	750,000	3,670,000
	3	800,000	4,470,000
	2	860,000	5,330,000
	Low	1	1,230,000

Most lived in the community, with only 7 per cent of all adults with disabilities living in some form of residential institution. The proportion of the latter increased with severity of disability – to just over half in category ten. Among disabled adults of working age, less than a third were in paid employment – but this included about half in category one with hardly any in category ten. Disabled adults tended to have incomes broadly in line with those of pensioners; thus the incomes of disabled adults of working age were substantially lower than the incomes of other working members of their age group, though higher than those of the unemployed:

Average equivalent income	Disabled people	General population
Pensioners	£91.90	£ 93.70
Non-pensioners	£98.30	£136.50

Asked about the extra costs incurred as a consequence of their disability (to pay for such things as home services, extra fuel or special food) people in the survey reported the average cost of this expenditure as £3.20 for those in category one, rising to £11.70 in category ten.

### **Social security and disability**

It is only during the past twenty years that the social security system has recognised disability as a particular subject for consideration. In the past, disabled people could claim ordinary benefits if they were



unable to work in the same way as those who were unemployed or retired, without reference to their disabling conditions. There were, nevertheless, special schemes to compensate people whose capacity to work had been impaired while at work or in the armed services. During the 1970s, however, a series of mainstream social security benefits was introduced specifically for disabled people; thus the concept of compensation for injury began to give way to the objective of meeting needs.

But in the major review of the social security system launched in 1984, disability benefits were not included. Instead, the government commissioned the OPCS to carry out the large scale survey (see above) in order to estimate the prevalence of disability in the population and to describe the circumstances of disabled people. Disability benefits were then to be reviewed in the light of the survey findings. The result of that review was published as *The Way Ahead* – ‘a major government statement’ – in January 1990. Some of the proposals in that document were incorporated immediately into the 1990 social security bill; others, it was recognised, required further development and were open to public discussion for a period and later included in the 1991 bill.

Debate about disability benefits has focussed on four main policy issues. A prominent feature of the discussion has been concerned with the complex structure of existing provision. Twenty-two benefits and parts of benefits could be identified at the time when *The Way Ahead* was published. Should they, the argument has gone, be rolled into a comprehensive benefit, perhaps with two or three elements, designed to meet all eventualities? Or does the present battery of provisions cater for a wider range of variation in individual circumstances?

Secondly, debate has centred on the issue of earnings replacement. How can people who are unable to work as a result of their disabilities be provided with an adequate income? Should this be based on national insurance contributions or on disability only? Should the amount vary between people whose disability arises from different causes? How can people who are capable of working be enabled and encouraged to do so?

A further matter for concern has been the recognition that there may be extra costs associated with disability which should be covered. Attempts have been made to assess how much extra people with disabilities need to spend – on heating, laundry, travel costs and so on – in order to maintain a similar standard of living as other people. The

further issue then arises of how can benefits be designed to meet these extra costs.

Lastly, and more fundamentally, the choice between the role of cash benefits and the direct provision of services has begun to be examined. During the 1980s, supplementary benefit started to be used, in a completely unintended way, to pay people's charges in residential care. How far, it might be asked, will other income maintenance provisions (attendance allowance, the social fund, the independent living fund) influence the policy of care in the community? And as an issue of principle, the question of placing cash directly in the hands of disabled people to buy the services they require for themselves arises. Many people have begun to see this as the key to empowering disabled people. A further, but rather different, issue – although related to the cash and services question – relates to the changing role of local authority service provision. How far will disabled people be expected to contribute out of their own purses towards those community care services?

Within this broad debate, many disability organisations have argued for a comprehensive disability benefit, to replace the patchwork of existing arrangements. Failing that, they argue that a set of long-term objectives should be identified to be reached in stages. The main elements of their proposals are:

- an income replacement benefit without contribution conditions;
- a disablement costs allowance to cover a wide range of additional needs associated with disability (they challenge the figures cited in the OPCS survey);
- a partial incapacity benefit designed to encourage independence through employment of people who are not completely unable to work;
- an upgraded carers' benefit, possibly set at a higher rate for people who have been prevented from working because of long-term care responsibilities and at a lower rate for working carers in recognition of the stresses they have experienced;
- reduced reliance on income support and other means-tested benefits: disability benefits should be available as of right and be set at a level to keep disabled people's income clear of the means-test line.

The government's policy statement, *The Way Ahead*, included three main proposals for improved benefits and two for reduced benefits:

*Improved benefits*

- an age-related addition payable as a supplement to the severe disablement allowance to be paid at higher rates for those disabled earlier in life and therefore least likely to have built up contributions to national insurance or occupational benefits;
- a disability allowance (later renamed the disability living allowance) to provide help to more people with the extra costs of disability and incorporating the current attendance and mobility allowances;
- a disability employment credit (renamed the disability working allowance) for people in low paid work – means-tested and similar to family credit.

*Reduced benefits*

- stopping the build-up of further entitlement to the earnings related additional pension paid to invalidity benefit claimants under SERPS;
- phasing out the reduced earnings allowance (and the linked retirement allowance) of the industrial injuries scheme; no new allowance would be awarded.

While the government estimated that benefit expenditure based on these proposals would increase over the medium term, long-term savings on the additional pension and reduced earnings allowance would be substantial.

Reactions to the proposals ranged from 'an insult to disabled people' (Disability Alliance) to 'imaginative proposals [which] will significantly improve the system of benefits available for disabled people' (Social Security Advisory Committee). The positive proposals (see above) have been seen as a step in the right direction but it can be argued that they did not go far enough. Those who had hoped that the OPCS survey and the review would lead to a comprehensive disability benefit were disappointed; there will be as many different benefits once all the reforms are enacted as before. In addition, although the majority of people with disabilities are over pension age, provision for their extra needs will remain substantially

worse than that available to non-pensioners with disabilities. There has been significant opposition to the plans to reduce spending.

### **Social and community care: services for disabled people**

During the 1970s, care in the community became a central part of government policy. White Papers – *Better Services for the Mentally Handicapped* and *Better Services for the Mentally Ill* – were published in 1971 and 1975 respectively, and on elderly people, *A Happier Old Age*, in 1978 (DHSS, 1971; DHSS, 1975; DHSS 1978). These client groups were also the focus for the major statement on priorities in *Priorities for Health and Personal Social Services* in 1976 (DHSS, 1976). In all of these, services were planned to be provided in the community rather than in institutions; the framework for the pattern of future services was thus established. It is important to note, however, that the only policy measure relating specifically to services for people with physical disabilities was that established in the Chronically Sick and Disabled Persons Act, 1970 – and this was a piece of legislation introduced and piloted through Parliament by a private member (Alf Morris). Furthermore, while disabled people were given rights in the act to certain community support services, these rights were not consolidated by mandatory duties on the part of local authorities to provide the necessary services. A further piece of legislation relating to services for disabled people, again introduced and piloted through Parliament by a private member (Tom Clarke) was the Disabled Persons Act, 1986 which sought to give more substance to disabled people's rights – by giving them the right to have their needs assessed by the local authority. Again, though, no mandatory obligation was placed on those authorities then to provide services which were needed.

Although community care came to be accepted as the appropriate objective for services for people with mental and physical disabilities and for elderly people, provision since the time the policies were established has been notably patchy and uncoordinated (Hunter and Wistow, 1987). At the same time, other developments have taken place which have upset policy expectations about progress towards community care. For example, as already mentioned, by the mid-1980s, a significant proportion of the social security budget was finding its way into the residential care sector because elderly people in receipt of supplementary benefit were able to claim the costs of care

and accommodation in private sector residential homes. This set in train an unplanned and unforeseen movement into residential care which was in opposition to stated policy.

Deficiencies in the provision of services in the community and failures to make any major inroads into the balance between the institutional and community sectors were reported by the Audit Commission in 1986 (Audit Commission, 1986) and resulted in Sir Roy Griffiths being appointed to undertake a review of the whole policy of community care in that same year. In reporting his findings two years later (Griffiths, 1988), he confirmed the patchiness of service provision in the community and recognised the perverse incentives of the social security system in favouring private residential care. He concluded that greater collaboration between service providers (a prerequisite for effective service provision) could only be achieved by clearer definitions of the boundaries of responsibilities between them. Thus he argued for the need to separate responsibilities for *social* care on the one hand and *medical/health* care on the other. More importantly, he advocated lead responsibility for the non-medical components of community care being placed in the hands of local authorities and stressed the importance of the 'mixed economy of welfare' – integrating public sector, private and voluntary sector services into a comprehensive range of provision.

His recommendations were broadly accepted in the White Paper *Caring for People* published in November 1989 (Department of Health, 1989). As he had advocated, local authorities were to be given overall responsibility for social care. But the amount of resources to be made available was not specified nor was there any provision for social care budgets to be protected from encroachment by other areas of local authority spending. One of the chief responsibilities placed on local authorities was to undertake assessments of anyone seeking care and to devise 'packages of care' according to the recommendations of the assessments. Thus local authorities – through their social services departments – were to become gatekeepers to care and services. They were to look at the needs not only of those requiring services and care but also of those currently providing care on an informal basis, usually family members. Their responsibility would be to put together the best possible mix of services to support the client and his/her informal carers, thus allowing him/her to remain in the community. It was envisaged that a 'case manager' or 'care

manager' would take responsibility for negotiating the best package for the individual client with a range of service providers. At the same time, the care manager would be responsible for a budget and thus have to balance the costs of care and services that ought to be provided against the needs of particular clients.

The proposals contained in *Caring for People* were incorporated into the National Health Service and Community Care Act, 1990 but almost immediately the Department of Health announced that implementation of most of the community care parts of the act would be delayed. The development of community care plans envisaged by the act, whereby local authorities and health authorities would collaborate in planning coordinated services, along with progress towards comprehensive assessment as a precursor to gaining access to services have therefore been left, at least until 1993, to the variable inclinations of authorities across the country. Progress is likely to continue to be patchy.

As attempts have been made to develop community care services, there have been parallel moves to gain recognition of the role played by informal carers. Successive policy documents have stressed the importance of informal care in community care provision – for example, the White Papers on elderly people, *Growing Older*, in 1981 and *Caring for People* in 1989 (DHSS, 1981; Department of Health, 1989) – but much of the impetus for that recognition has depended on the efforts of campaigning groups in the voluntary sector. Surveys carried out during the 1980s have identified how significant a part is played by informal care. The General Household Survey (Green, 1988) estimated that there were more than 6 million informal carers although the sort of care provided varied in its range and intensity.

While current policy stresses the need to take the interests of both the person requiring services and/or care and the informal carer into account, there may on occasions be conflicts of interest between the two. This is an issue which is never really addressed in official discussion of how community care should develop but it is an important one both in terms of how access to formal services is regulated and in the debate about putting cash into the hands of the client so that s/he can buy services as required.

### **Disability and employment**

While the Departments of Social Security and of Health were reviewing their services for disabled people, the Department of Employment was also active. It commissioned its own major survey, *Employment and Handicap* (Prescott-Clarke, 1990), and published a Consultative Document, *Employment and Training for People with Disabilities* (Employment Department, 1990).

Current policy on employment can be traced back to the Disabled Persons (Employment) Act 1944, under which an official register of disabled people was set up. Although there have been many changes of detail, the three-pronged strategy adopted then is still recognisable today. Disabled people may be offered training or rehabilitation to improve their employment prospects; sheltered employment is available to people who are unable to undertake ordinary work; and employers are required to maintain a quota of at least three registered disabled workers for every hundred employees.

A number of issues arise in any discussion about policy on disabled people and employment. One of these is the degree to which disability has an impact on earning capacity. Occupational handicap occurs at the junction of two problems: a physical or mental impairment affecting an individual; and the failure of the employment market to offer an appropriate job. In principle, it is possible to think of four ways in which physical or mental impairment might affect individuals' capacity to earn their living. Some individuals may be quite unaffected while others might face handicaps in terms of access, communication and so on but would be capable of fully productive work if those barriers were eliminated. A third group might be those who can work, but whose output is limited to varying degrees compared to that of other people. Lastly, some disabled people may be wholly unable to take employment.

The initial questions for policy research are related to the relative sizes of these four groups. In particular, there may be a substantial number of people who could work but have been prevented from taking employment by barriers of access or communication. While they appear to be in the fourth category (of those unable to work), they should be placed in the second.

Further issues arise: in the attempt to design policies which will maximise the opportunities for disabled people to gain access to the employment market, what should the balance be between policies

aimed at the individual and those aimed at employers? Policies aimed at individuals include training, rehabilitation, counselling and job-finding services. An assessment must be made of the effectiveness of existing services along with an estimate of how far the improvement and development of these services would be likely to solve the difficulties faced by disabled people in gaining access to employment. A secondary issue relates to who should pay for them and how they should be organised.

Policy aimed at employers has to consider whether employers have a duty to hire disabled people and adjust their premises or working practices accordingly. Should they be encouraged to adopt good practice by exhortation or through a combination of carrots and sticks? The existing quota scheme does not work: it can be argued that it should either be enforced or scrapped. Some have argued that anti-discrimination legislation (similar to the Race Relations and Equal Opportunities Acts) would be more effective. There may therefore be a variety of ways forward.

One of the most important policy issues in the employment field relates to the role of income maintenance. The aim of policy should, perhaps, be to design tax and social security schemes which enable disabled people to earn their own living and which do not discourage them from doing so, but which also do not penalise those who are unable to do so. The OPCS survey of disabled adults and the SCPR survey of employment and handicap (both mentioned earlier) suggested that there are more than two million people of working age who are affected by disability in various ways:

	OPCS	SCPR
Economically inactive:		
permanently unable to work	720,000	
others	530,000	
	1,250,000	1,440,000
Economically active:		
wanting work	210,000	280,000
in employment	650,000	990,000
	860,000	1,270,000



The OPCS survey showed that the proportion of people who say they are permanently unable to work rises at higher levels of disability, from one fifth in severity categories 1 and 2, to three-quarters in categories 9 and 10. Only 5 per cent of the most severely disabled men and women of working age are in employment. Both surveys showed that disabled/handicapped workers (the terminology is that which the surveys used) earned less than other workers, even when hours were taken into account. OPCS reported that disabled men earned £3.80 per hour, compared with £4.50 per hour among the population at large. SCPR said that 38 per cent of the male full-time employees in their sample earned less than £150 per week, compared with a national average of 14 per cent.

The ED-sponsored survey (SCPR) provided a particularly valuable insight into the impact of the Disabled Persons Register, and of the services available to its members. Disablement Resettlement Officers judged that the majority of the SCPR sample were eligible to register – a national total of more than one million. Although more than half of them had heard of the register, only 14 per cent were currently members of the scheme. More than 350,000 people were considered to require sheltered employment but less than a tenth of that number were actually *in* sheltered employment. Again, only one eighth of occupationally handicapped people had ever received advice from a Disablement Resettlement Officer; fewer still had participated in any specific disability-related employment service.

Since the majority of people in the SCPR sample had jobs, it might be argued that they did not need specialist services. The figures nevertheless suggest that public employment policy operates at the margin rather than in the mainstream of the relationship between disability and employment. It is in this context that the proposals put forward in the Consultative Document (Employment Department, 1990) have to be considered.

Broadly speaking, the proposals fall into two categories: creating more job opportunities and helping people with disabilities seize those opportunities. In the first category, the document is concerned with reinforcing arrangements for encouraging and supporting good practice by employers and with modernising arrangements for creating job opportunities for severely disabled people. In addition, it advocates recognising the opportunities that may be available to disabled people for self-employment.

In the second category, concerned with assisting disabled people to seize opportunities, the document recommends strengthening the capacity of non-specialist employment and training services to help disabled people, along with providing a more integrated and professional Employment Department specialist service. It also argues for more use of bought-in expertise and help from voluntary and employer organisations – indeed, the majority of rehabilitation services would be contracted out. Lastly, steps should be taken to establish how people with multiple problems may be better assisted.

These reforms are designed to bring about improvements to existing policies and services. They do not, however, add up to the fundamental reappraisal that many members of the disability movement had been proposing. In particular, there has been widespread disappointment at the Department's reluctance to grasp the nettle of enforcement of obligations on employers. Many commentators argue that an unenforced quota scheme only sends the wrong message to employers, and stands in the way of the development of a more effective policy.

### **Conclusion**

This chapter has been concerned with setting out some of the conceptual issues at the heart of the discussion about policy on disability and with outlining some of the factual background to recent developments in the fields of social security, social and community care, and employment. The following chapters will address these topics in greater detail. They represent a variety of approaches and do not provide a consensus about the future direction of policy. Nevertheless, by assembling this wide-ranging set of contributions, it is hoped to further current debate.

### **References**

- Audit Commission (1986) *Making a Reality of Community Care*, London, HMSO.
- Bone, M. and Meltzer, H. (1989) *OPCS Report 3, The Prevalence of Disability among Children*, London, HMSO.
- Dalley, G. (1988) *Ideologies of Caring: Rethinking Community and Collectivism*, London, Macmillan.
- Department of Health (1989) *Caring for People: Community Care in the Next Decade and Beyond*, Cm. 849, London, HMSO.

- Department of Health and Social Security (1971) *Better Services for the Mentally Handicapped*, Cmnd. 4683, London, HMSO.
- Department of Health and Social Security (1975) *Better Services for the Mentally Ill*, Cmnd. 6233, London, HMSO.
- Department of Health and Social Security (1976) *Priorities for Health and Personal Social Services in England*, London, HMSO.
- Department of Health and Social Security (1978) *A Happier Old Age*, London, HMSO.
- Department of Health and Social Security (1981) *Growing Older*, Cmnd. 8173, London, HMSO.
- Department of Social Security (1990) *The Way Ahead: Benefits for Disabled People*, Cm. 917, London, HMSO.
- Employment Department (1990) *Employment and Training for People with Disabilities*, London, Employment Department Group.
- Green, H. (1988) *Informal Carers*, General Household Survey, London, HMSO.
- Griffiths, Sir R. (1988) *Community Care: Agenda for Action*, a report to the Secretary of State for Social Services, London, HMSO.
- Hunter, D. and Wistow, G. (1987) *Community Care: Variations on a Theme*, London, King Edward's Hospital Fund for London.
- Martin, J., Meltzer, H. and Elliott, D. (1988) *OPCS Report 1, The Prevalence of Disability among Adults*, London, HMSO.
- Martin, J. and White, A. (1988) *OPCS Report 2, The Financial Circumstances of Disabled Adults living in Private Households*, London, HMSO.
- Martin, J., White, A. and Meltzer, H. (1989) *OPCS Report 4, Disabled Adults: Services, Transport and Employment*, London, HMSO.
- Meltzer, H., Smyth, M. and Robus, N. (1989) *OPCS Report 6, Disabled Children: Services, Transport and Education*, London, HMSO.
- Oliver, M. (1990) *The Politics of Disablement*, London, Macmillan.
- Prescott-Clarke, P. (1990) *Employment and Handicap*, London, SCPR.
- Smyth, M. and Robus, N. (1989) *OPCS Report 5, The Financial Circumstances of Families with Disabled Children living in Private Households*, London, HMSO.