

Welfare States and Disabled People

16

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This chapter is concerned with the impact of welfare states on disabled people in Western, industrialized countries. I deal first with competing definitions of the concept of the “welfare state” and then explore the development of welfare. I argue that two key aspects are of particular importance in fashioning the experiences of disabled people. These are the structure of income distribution through welfare and the supremacy of a medical understanding of disablement.

In formulating their social security systems, many Western states have distinguished between contributory (earnings-related) benefits and noncontributory (often, means-tested) benefits. When employees have been able to subscribe to schemes that provide earnings-related benefits, their subsequent nonwork income is generally above subsistence level and, in some countries, such as Sweden and Germany, could be very close to their erstwhile level of earnings (Ginsburg 1993; Wilson 1993). However, many disabled people may not have done paid work at all and may not have contributed either to earnings-related schemes or to private insurance. Many thus rely on “safety net” systems of social assistance or “flat-rate” allowances (Oliver and Barnes 1998). The main point here is that states may keep noncontributory levels of benefit deliberately low to discourage benefit dependency on social security and encourage unemployed people back into work (Andrews and Jacobs 1990). The option of resuming work may be closed to some disabled people, who may consequently command only low levels of income for much of their lives (Berthoud, Lakey, and McKay 1993).

The second key aspect of the relationship between welfare states and disabled people has been the prevalence of medical understandings of disability. In subscribing to a medical model of disability, both society at large and the institutions of health and social services have regarded disabled people as “defective” in some way. The project of medicine has been to treat, ameliorate, or “normalize” disabled people according to prevailing understandings of physiological and cognitive norms (Barnes, Mercer, and Shakespeare 1999; Oliver 1990; Symonds and Kelly 1998).

In this chapter, I argue that a key historical effect of these two systems (social security benefits and medicine) has been either the conceptual or, indeed, the actual segregation of disabled people from society at large. Public responses ranged from fear to pity and from punishment to “care” (Hevey 1992; Oliver 1990). Disabled people have been stigmatized through the powerful mechanisms of conformity that operate as part of everyday life to secure the cohesion of society (Becker 1963; Giddens 1993; Goffman 1969, 1970; Lemert 1962). Only in more recent times have we witnessed a reappraisal of welfare policy. A new civil rights paradigm is emerging in which the problems faced by disabled people are recognized as sociopolitical in origin. In-

creasingly, the environment, as opposed to the individual, is becoming the focus for change (Oliver 1996).

The final section of this chapter assesses some of the tangible impacts of welfare on disabled people. I begin by discussing the economic consequences that flow from dependency on benefits or low-paid work. I then turn to social and environmental outcomes, including aspects of education and growth, domicile, location, transportation, and mobility. Finally, I consider political implications for disabled people.

WELFARE STATES

In writing about welfare states, scholars often begin by warning how difficult the concept is to define. Lowe (1993), for example, tells us that there is “no agreement amongst historians or social scientists over when the first welfare states were established or what the term actually means” (p. 9). In a similar vein, Hill (1993) contends that attempts at welfare state macro-theory have yielded only low levels of specificity and are of limited utility in applied studies. One of the key problems, perhaps, is the diversity in the extent of welfare provision. Some states, particularly the Scandinavian countries, have built extensive and universally available systems of welfare (Ginsburg 1983, 1993; Gould 1988, 1993). Other states engage in what Mabbott and Bolderson (1999) called “residualism.” In places such as the United States and Hong Kong, citizens are expected to make their own provision through private insurance or reliance on the family. Administrations thus adopt a far more residual role, providing only means-tested and basic (safety net) services to the most vulnerable in the population (Mabbott and Bolderson 1991; McLaughlin 1993).

Welfare states have emerged principally in societies with high levels of democratic participation and industrialization (Ashford 1986; Esping-Andersen 1990; Hill 1993). Within a functional analysis, Mishra (1977) saw welfare states as instruments of social reform, social administration, and social engineering. However, others, in stressing the differences between national welfare states, have explained considerable degrees of divergence by referring to unique historical circumstances in their evolution (Cochrane and Clarke 1993; Fraser 1984; Jones 1991). Finally, some scholars have analyzed welfare states according to their main (and common) purposes. From this perspective, Blakemore (1998) and Baldock et al. (1999) define welfare systems in terms of the range of institutions that together determine the welfare of citizens. These institutions usually include health, education, housing, and social security or income maintenance.

I do not wish to deny the utility of any of these approaches. Each reveals its own insights about state welfare in the contemporary world. However, as the task in this chapter is to mainly assess the relationship between welfare states and disabled people, I will concentrate on the evolution and the impact of welfare states in just two key respects: income and health. Clearly, disabled people’s experience of social institutions will vary over time and among states. The precise outcomes of policies will differ from country to country, as will the consequences that flow from them. It is possible, nevertheless, to discern some common impacts.

THE EMERGENCE OF STATE WELFARE

Public services come into being for a number of reasons, although specific circumstances may have varied among nations. Several common economic, social, and political influences led to the development of welfare states in the twentieth century. With the growth of capitalist economies and international competition between states, each saw the need for fit and healthy workers and strong military forces (Searle 1971; Semmel 1960). In every population, however, there

were those who could not meet these requirements, and, at least in part, state welfare emerged as a response to this problem (Alcock 1993; Novak 1988; Spicker 1993).

In Britain, for example, early social research by Hyndman (1911), Booth (1903), and Rowntree (1901) revealed that as Queen Victoria's reign came to a close, some 30 percent of her subjects dwelt in perpetual poverty. There were other concomitant social problems such as high perinatal mortality rates, poor nutrition in the workforce, poor housing, overcrowding, disease, and dependency in old age (Burnett 1986; Finer 1999; Gauldie 1974; Lewis 1980; Stedman Jones 1971).

Governments came under pressure to intervene from the findings of social research, the records of medical officers of health, and the documentation supplied by philanthropists and charities. These were supplemented by protests from militant trade unions representing the unskilled laboring classes; from the birth of radical political groups, such as the Social Democratic Federation and the Labour Party; and from new political voices emerging from the extension of the franchise through the reform acts of 1832, 1867, and 1884 (Harris 1972; Jenkins 1994; Rose 1972).

Governments had been content to leave the "problem" of the poor, the marginalized, and disabled people to philanthropists and were reluctant to intervene in what were seen as individual tragedies. Unsurprisingly, therefore, the first official responses were both ad hoc and fragmented. Nevertheless, between 1906 and 1914, the Liberal administrations of Campbell Bannerman and (from 1908) Asquith introduced unemployment and sickness benefits, subsidized school meals, provided regulations for the training of midwives and services for the medical inspection of schoolchildren, and extended educational opportunities and Britain's first old-age pension (Hay 1978; 1975; Rowland 1971). Through the interwar years, a more incisive understanding of the causes of poverty was developed by William Beveridge (1942), leading ultimately to the formulation of his plans for social security based on mutual insurance (Timmins 1995).

In addition, the two world wars gave impetus to the development of health services and enhanced the status of the medical professions. In 1918 and 1919, hundreds of thousands of men returned from the Great War permanently impaired. Many of them had been gassed or blinded in the trenches of Paschendale, Ypres, the Somme, and all along the Western front. The combatant nations felt they had moral obligations toward their war wounded (Bourke 1996). Initial policy responses were, however, rather uncoordinated, haphazard, and not particularly generous (Sainsbury 1993). There are two key points here. First, as with industry and commerce, the strength of the armed forces depended on the successful reproduction of a healthy, well-nourished, and "able-bodied" population. Health services had thus to deal with both the requirements and the consequences of war. Second, the creation of so many disabled people in wartime was met with a rapid expansion of health services. Society's response to disability was naturalized within the context of medicine.

In sum, welfare states were intended to provide health services and education to underpin a nation's military, industrial, and economic requirements. Welfare states were also a product of social concerns, about overcrowding, poor housing, and poverty. Finally, they were responses to political pressure from radical groups and threats to the social fabric in the form of protest and riot.

DISABLED PEOPLE IN THE EARLY WELFARE STATE

How was it, then, that in large numbers, disabled people came to rely on welfare for their livelihoods? There can be no natural or preordained reason for the fact that so many found themselves dependent on the benefaction of the state.

To deal first with economic factors, Finkelstein (1981) argues that much of the responsibility for disabled people's plight rested with the gradual change in the nature of work that resulted from the industrialization of the Western world. Prior to the advent of heavy industry, disabled people enjoyed legitimate, valued, and productive roles within their local communities. However, as production became increasingly mechanized and required greater speed, they were gradually excluded from work because new tools and instruments were built to designs that could, by and large, be used only by people who had no significant physiological impairment. Those who could not work were quickly differentiated from those who would not work, but both groups were segregated from mainstream society (Ryan and Thomas 1980; Topliss 1979).

While the "idle" and "undeserving" were met with deterrent (and sometimes brutal) measures, the "deserving" poor might hope for philanthropy from the well-to-do (Ditch 1991; Owen 1965). Punitive regimes took different forms in different countries. In Britain, prior to and during the nineteenth century, a pauper family no longer able to provide for itself might be committed to the dreaded institution of the workhouse, an establishment in which families would be segregated in large dormitories, given meager rations, and put to sweated labor or loaned out to local farmers as additional labor (Crowther 1983; Novak 1988). There is also evidence that between the 1780s and 1860s, at least some disabled people were convicted as criminals and transported to Australia (Hughes 1987).

While some disabled people might be incarcerated as paupers or criminals, others would have been counted among the deserving poor and have received alms or asylum (Kirkman Gray [1905] 1967). In Britain, philanthropy became a major part of Victorian society, and as far as disability was concerned, charitable and voluntary activity became increasingly organized within the worldview of medicine (Jones 1991; Nightingale 1973). This legacy has meant that even today, a significant proportion of voluntary organizations still include some specific medically defined condition in their names (the Spina Bifida Association, the National Schizophrenia Fellowship, the Parkinson's Disease Society, the Muscular Dystrophy Society, the Alzheimer's Disease Society). These organizations continue to define their membership in similarly diagnostic and delimited terms (Brilliant 1990; Drake 1992a, 1994, 1996b; Stanton 1970).

MODERN STATE WELFARE

Clearly, the growth of state involvement and the particular shape that it took differed from country to country. However, I have argued elsewhere (Drake 1999) that we may commonly detect four overlapping strands in the evolution of disability policies and the development of welfare services more generally. These are containment, compensation, care, and citizenship. Reference has already been made to early policies in the British context where containment stood as a preeminent aim. It entailed the removal of disabled people from the community into prisons, workhouses, almshouses, or hospitals. I have also discussed the idea of "compensation" as it applied to people injured at work or wounded in World War I and World War II and who, according to the origin of their impairments, might expect differential forms of help from the state. These benefits might include war pensions, disability allowances, tax or other relief, and health and rehabilitation services (see Drake 1999:49-57).

In more recent times, the third strand of policy response, "care," came to the fore. Here I refer to the development, particularly in the latter part of the twentieth century, of more tangible, widespread, and direct state programs. Such programs include daycare services, "special" education, sheltered employment, occupational skills training, health care, prosthetic services, community-based personal social services, and broader social assistance or social security programs, providing more specific forms of financial support according to an individual's condition (Hill 1993; Lowe 1993). The extent to which such services have been developed and the

degree to which they cohere vary between states. Common wisdom has it that in the half century following World War II, Sweden and the Scandinavian countries created perhaps the most extensive welfare programs (Ginsburg 1983, 1993; Gould 1988; Ronnby 1985). A second group, of which Britain was typical, produced piecemeal and rather uncoordinated services inaugurated at different levels of government and managed by differing departments of state (Barnes 1991; Lowe 1993; Oliver 1990, 1991; Timmins 1995). Yet other countries, such as the United States, Canada, and Australia, looked as much to civil rights mechanisms as to social services (Drake 1999; Tucker 1994) (see below).

These different approaches have resulted in wide variation in expenditure. Certainly, there are clear differences in the proportions of gross domestic product (GDP) devoted to social security (Organization for Economic Cooperation and Development [OECD] 1999). Even so, in the past three or four decades, care services have expanded rapidly in many countries. For example, the number of welfare staff in Sweden increased from 35,000 in 1960 to 160,000 by 1975 (Ronnby 1985). In Britain, there were 7,828 welfare workers in 1959. By 1995, the whole-time equivalent staffing of English social services departments had reached 233,862 (Department of Health 1996).

The prime focus of health and social services continues to be on disability as a personal condition. Welfare is still significantly about changing the individual to fit into the social and physical environment rather than altering the social, political, and physical contours of society. Following the International Year of Disabled People in 1981, however, some administrations began to respond to the challenge of national disability movements that governments must recognize disability as a civil rights issue (Barnes 1991; Crow 1990; Hasler 1993; Pagel 1988). New kinds of laws emerged, particularly in the United States, which were aimed less at extending welfare provision than at securing a framework of legal rights through which disabled people might achieve greater and ultimately equal access to the key institutions of civic and public life (Scott 1994). It is to this concentration on legal and environmental change that I refer when I speak of a fourth orientation of policy: the development of citizenship.

Citizenship is not an easy concept to define, but many writers see "participation" as being the crux of the matter. For Barbalet (1988), citizenship defines who is and who is not a member of a society. Similarly, Turner (1993) contends that membership is realized in a set of practices concerned with law, justice, economics, and culture. Voet (1998) argues that of all these, a share in governance is perhaps the most critical. While some scholars, such as Marshall (1992), stress the rights conferred by citizenship, others, such as Scruton (1982) and Joseph and Sumption (1979), underline the responsibilities that citizens owe to the state. We may say, then, that when a person has no access to governance, society, or an economy, when he or she neither fulfills duties toward a state nor enjoys rights guaranteed by it, then such a person has no citizenship. I should add, however, that there are questions of degree here. Without being destroyed completely, a person's citizenship could be damaged or infringed on. For example, inequality of opportunity can enhance the life chances of some and increase their privilege in exercising economic and political power. However, at the same time, others may be excluded from political, economic, and social structures, thereby diminishing the scope of their potential and actual participation in society (Baker 1987; Tawney 1964). Unsurprisingly, many marginalized groups, including disabled people, frequently describe themselves as being oppressed and treated like "second-class citizens," meaning that they regard their citizenship as being of a quality inferior to that enjoyed by the majority (Brisenden 1986; Campbell and Oliver 1996).

Few, if any, nations can claim to have achieved comprehensive and well-integrated ("joined-up") sets of policies, which together secure the full inclusion of disabled people in contemporary society. It remains more typical to encounter welfare policies and systems that are residual, piecemeal, and far from exhaustive (Howard 1999). Why, then, has it proved so difficult to create legislation that guarantees the citizenship of disabled people? In the next section of this chapter, I argue that both historical and current conceptualizations of "welfare" play a large part in this failure. Indeed, the term itself may be formulated in accordance with doctrines that are to some extent antithetical to citizenship.

WELFARE AND CITIZENSHIP: A CLASH OF PRINCIPLES?

In seeking to define (or to redefine) welfare, contemporary governments have sought to reconcile principles that are abrasive with respect to each other. On one hand, there has been a desire (or at least a perceived duty) to support "those in genuine need." (Of course, what is critical here is the definition applied by governments to the term genuine need and the subsequent nomination of groups deemed to fall within the chosen definition.) On the other hand, governments have been determined to protect capitalism and support the work ethic by blocking or excluding from welfare programs all those thought to be abusing or defrauding the welfare system. These restrictive aims are explicit, for example, in the guidance issued in the United States by the Social Security Administration:

Disability under Social Security is based on your inability to work. You will be considered disabled if you are unable to do any kind of work for which you are suited and your disability has lasted or is expected to last for at least a year or to result in death. Some consider this a strict definition of disability and it is. (Social Security Administration 1997:4)

The program assumes that working families have access to other resources to provide support during periods of short-term disabilities, including workers' compensation, insurance, savings, and investments.

Two key mechanisms are commonly used in judging whether claimants are entitled to benefits: means testing and medical evaluation. When an allowance, benefit, or other form of help is means-tested, the applicant must disclose to the authorities private information about income, savings, and property. If the applicant's wealth exceeds some given figure, the claim for the particular benefit is rejected. Some states extend the calculation beyond the individual to take into account resources available within the immediate family, and some states look to the extended family as well before making a benefit available (Jones 1993; McKay and Rowlingson 1999).

The second testing mechanism of particular relevance to disabled people is medical evaluation. In addition to diagnosis by doctors nominated by the state, there may also be extensive inquiry (often involving intimate questions or examination) into the capacities and incapacities of a claimant. "How many steps can you take without a stick or chair?" "Can you wash yourself without help?" "Are you able to use the lavatory unaided?" The answers to such questions, plus reports from doctors, are critical in determining whether particular resources or allowances are made available to a claimant (Kirk 1999).

The desire to minimize welfare expenditure is epitomized in policies such as the "workfare" program pursued in Wisconsin (Kaus 1995; Mead 1997; Rector 1997; Scully 1998). It is also evident in recent alterations to British social security law restricting access to incapacity benefits and other disablement allowances (Berthoud 1995; Berthoud et al. 1993; Digby 1989; House of Commons 1998; Walker 1991). Here, the emphasis is clearly on the more selective targeting of allowances and other benefits. In asking how disabled people experience welfare in any particular state, much of the answer will thus depend on the criteria on which welfare stands and the structures through which a system is delivered. In sum, welfare systems have, as a prime concern, the need to restrict access to protect economic (wealth-producing) structures. These same structures militate against disabled people's access to work and thus to resources.

Clearly, then, we may detect a certain measure of incongruity between the principles governing welfare as an aid to citizenship, on one hand, and as protection for the economy, on the other. I explore the potential contradiction brought about by these desiderata more fully in the next section.

SEMANTIC AND STRUCTURAL CONTEXTS OF WELFARE

Welfare systems built on (medically inspired) definitions of disability will comprehend disability as stemming from individual, as opposed to social and environmental, causes (Barnes et al. 1999; Barnes and Mercer 1996; Priestley 1999). As a result of that understanding, attempts at change will be focused primarily on disabled individuals as opposed to disabling environments. Typically, then, welfare systems may make little impact on the political, social, economic, and physical environments in which they have evolved. These same environments can be alien to disabled people and may serve to impede their citizenship and participation in society. Indeed, the general purpose of welfare is to accommodate and sustain disabled people within these prevailing environments. Welfare services may therefore aim to restructure a person's physiology, for example, through invasive surgery or the provision of prosthetic aids or adaptations (see, e.g., Blumberg 1991). Or again, welfare may involve interventions aimed at producing changes in personality or cognition, for example, through the use of behavior modification techniques or "normalization" programs (see the critique by Chappell 1992). Finally, welfare may simply be used to palliate an individual by using services such as occupational or "diversion" therapy, leaving many disabled people unqualified and underemployed (Hyde 1996; Walker 1982).

Nevertheless, opportunities for disabled people to create their own self-governed structures have grown in recent years. Examples include the work of the Derbyshire Coalition of Disabled People (Priestley 1999), user governance in social work projects (d'Aboville 1991), user-directed residential services (Brown and Ringma 1989), and user-managed mental health projects (Barker and Peck 1987; Levy 1986). As opposed to actual self-governing projects, the notion of "participation" in the management of the welfare state has been more problematic. In joining preexisting welfare setups, particularly those in the statutory sector, disabled people have often found that they lack authority over and within them and have little control of the predominantly nondisabled personnel who manage and operate welfare programs (Beresford and Croft 1993; Drake 1997; Pithouse and Williamson 1997; Welsh Office 1989).

Finkelstein (1980:17) explained this powerlessness of disabled people by arguing that in any helper-helped relationship, the "helpers," by dint of their superordinate position, are able to exercise greater influence over defining the problem to be solved. When there is dissonance between society and a minority of citizens, the strong tendency is to locate pathology in the person or group rather than in the surrounding status quo. The basis on which "welfare" is offered, therefore, is one that demands of disabled people not only acquiesce in helper-based definitions of the welfare relationship.

Several researchers have noted how in practice disabled individuals often adjust to these circumstances by adopting roles and expectations appropriate to the dependency thus created (Albrecht 1976; Albrecht and Levy 1981; Rose and Black 1985; Safilios-Rothschild 1970; Scott 1970). Moreover, Bloor (1986) highlights the fact that the construction of dependency may occur not as a result of any overt use of power by welfare staff but by means of "social orchestration":

Because of their practised grasp of community life, their skills as group therapists, but pre-eminently because of their pre-existing and continuous superordinate position staff were able to relinquish directive control of events but nevertheless predict, shape and act upon subsequent developments. A position of power converts mere anticipation of events into a capacity to orchestrate. (P 319).

Clearly, then, when disabled people lack authority within welfare structures, a key consequence is their concomitant lack of control over the purposes of such structures and the distribution of resources within them. Inasmuch as welfare systems are subservient to economic systems, it is not surprising to find that disabled people receive low levels of financial support

compared with their nondisabled counterparts who derive their incomes from employment. Even disabled people who have work tend to receive lower pay than nondisabled counterparts.

SUMMARY

Welfare states have developed as a response to poverty and “need,” but they also constitute mechanisms designed to protect vital state interests and national economic goals. Frequently, states intervened in “private” need principally because the sheer scale of want threatened to undermine the health of modern industry and trade. Medicine received the imprimatur of the state to diagnose and then deal with the “needs” of disabled people. These “needs” were (and, in large measure, continue to be) defined in terms of individual as opposed to environmental disorders, deficits, and disadvantages.

Given such origins, we may see how contemporary welfare systems struggle to respond to disabled people’s calls for citizenship and equality of opportunity. Against this background, it becomes easier to comprehend welfare not only in its ostensible roles of rehabilitation and support but also as a force for conformity and control. In the next section, I argue that the understanding on which welfare systems are based and the structures and forms they take may offer some material help, but along with tangible and useful aid, there are other, less desirable outcomes for disabled people.

OUTCOMES

The experiences of disabled people will depend on how welfare states are configured. Do they integrate or segregate? Are there equitable levels of income as between disabled and nondisabled people? How is citizenship conceived, and how far is it guaranteed? What power relationship is there between service users and providers? Clearly, welfare services may be liberating or constraining. The outcomes will depend on (1) the influence of disabled people over policy and purposes, (2) their position (if any) within management hierarchy, and (3) their involvement and experiences at the point of service delivery. I have said that the experience of welfare is contoured by the meanings and principles that shape any particular regime and by the mode of its delivery. I have also argued that at least two divergent aims vie for preeminence—the ostensible goal of providing support and the contiguous desire to control and, possibly, to exclude. In this part of the chapter, my aim is to consider three key areas in which there are outcomes for disabled people. These are economic consequences, social outcomes, and political implications.

Economic Consequences

Old soldier Jack Brayley, age 76, was just about surviving on £51 (\$83) per week. The money had to stretch to cover rent, gas, electricity, water, and rates bills. He spent about £15 (\$24) per week on food. He had no television because he could not afford the license. “I’m an invalid and I’ve been on a low income for some years,” said Mr. Brayley. “When I didn’t have money, I used to stay in, because I don’t believe in cadging [borrowing].” (“Old Soldier’s Pride” 1996:4)

Typically, noncontributory systems of financial benefits (social security or social assistance) provide resources very near to or actually below the lowest levels of wages earned by people in

work (Alcock 1993). Generally, the work available to disabled people tends to be lower paid and of lower status than that available to their nondisabled counterparts. So, for example, McNeil (1999) reports an average difference between the earnings of severely disabled people and nondisabled people in America of more than \$10,000 per annum. (The difference between salaries of people whose impairment was not severe and nondisabled people's earnings was more than \$5,000 per annum.) The same is true in Britain, where the weekly wage of disabled male workers represents only 81 percent of the average enjoyed by nondisabled males (Berthoud et al. 1993; Hansard 1989). More recent data from Blackaby et al. (1998) reveal that most disabled people earn less than their nondisabled counterparts, primarily because they occupy jobs demanding fewer skills and qualifications, and confirm Barnes's (1991) contention that they have less access to the more professional and well-paid posts. Indeed, disabled people tend to earn less than nondisabled people, even when they are doing similar (or even identical) jobs (Martin and White 1988). Finally, when they have work, many disabled people are "under-employed" (Royal Association for Disability and Rehabilitation [RADAR] 1993; Walker 1982).

In 1996, about 77 percent of nondisabled people were in paid work. This compares with just 32 percent of disabled people (Sly 1996). By gender, only about one-third of disabled men and about 29 percent of disabled women have jobs (Lonsdale 1990; Martin, White, and Meltzer 1989). There is substantial evidence, then, that both the level and the duration of unemployment among disabled people in Britain have been consistently higher than those experienced by nondisabled people (Clark and Hirst 1989; Glendinning 1991; Hirst 1987; Hyde 1996; Lonsdale 1986; Townsend 1979).

Some welfare systems, particularly in Scandinavia, seek to provide "sheltered" work or to help disabled people find work on the open market. This is also true in Britain, where the Department of Social Security employs disablement resettlement officers (DROs) and personal advisers. As Barnes (1991) points out, however, intercession with employers by DROs has the drawback of emphasizing difference by suggesting that disabled workers need special pleading, that they are in some sense inferior to nondisabled workers. The evidence is, however, to the contrary that, *ceteris paribus*, disabled people perform at least as well as and are often more reliable than their nondisabled counterparts (see Barnes 1991, chap. 4).

The key remaining question concerns those disabled people whose impairments may be so severe as to prevent them from taking up work even in the most conducive and best-adapted environment. As early as the 1970s, groups such as the Disablement Income Group and the Union of Physically Impaired against Segregation (UPIAS 1976) called for disablement incomes at a level that would allow these disabled people to maximize their citizenship to the fullest potential (Oliver and Barnes 1998). Other writers, such as Abberley (1996), have questioned the centrality of work as the (almost) sole arbiter of social status and access to economic resource and call for new ways of valuing people's lives and contributions to society. Income is an important element in determining disabled people's access to the social world. But just as critical is the configuration of the environment itself.

Social and Environmental Outcomes

What annoys me is, we can't even get in . . . corners, access, getting there by bus . . . there's always small corridors to go round. ("Peter," in Drake 1992b:225)

We are disabled by buildings that are not designed to admit us . . . the disablement lies in the construction of society, not in the physical condition of the individual. (Brisenden 1986:176)

I have said that welfare tends, in so many of its guises, to be focused on individual lives rather than the contours of the social and physical environment. In these circumstances, changes are wrought at the individual level rather than social and environmental levels. Perhaps a key out-

come in terms of individuals' experiences of welfare is that present policies and configurations may do little if anything to diminish the environmental obstacles that constitute disabling barriers.

Given its focus on individual causation, welfare commonly offers "solutions" in the form of personal aids, adaptations, and allowances so that individuals can negotiate their "given" surroundings, thus leaving those conditions unaltered. Social work in Britain, for example, is described as a "personal social service." Its aim is to provide "professional" help in solving "personal" problems. There is, however, no welfare agency whose task it is to alter the environment in which obstacles arise. The key areas, vital to participation in society, include growth (particularly educational growth), movement (including transport), and location (including domicile and access to buildings that serve the public).

Education

The historical expectation that disabled people might lead lives segregated from society at large meant that such education as they might receive fitted them poorly for subsequent life beyond the institution (Barton 1986, 1988). In many countries, more recent educational policies have favored the integration of disabled children into mainstream schooling. However, some commentators have asked whether such moves have aimed for genuine integration or simply aided the preservation of two sorts of education (for disabled and nondisabled persons), albeit under one roof (Barton 1986, 1988, 1989; Barton and Tomlinson 1981; Fulcher 1989).

I have already outlined some of the economic consequences that may flow when there is inferior education and lack of equality of opportunity. Potentially, there are also, however, consequences in other areas of life. When a disabled child is educated separately and less extensively than his or her nondisabled counterparts, he or she may enjoy fewer choices later on. Many careers, particularly those in the professions, demand specific qualifications, skills, and training. Those who do not possess the necessary attainments find the doors of such professions (e.g., accountancy, teaching, engineering, and the law) closed to them (Langdon-Down 1996).

Location and Domicile

When welfare services are targeted on individual as opposed to environmental change, they may fail to combat restrictions imposed on disabled people by the broader society. An important example of this effect occurs in housing with respect to both location and type. Choice between public housing and the private market, or between rented accommodation and home ownership, is only possible when disabled people command sufficient resources to be able, if they wish, to opt for house purchase and private ownership. However, Barnes et al. (1999) and Harris, Sapey, and Stewart (1997) show that most dwellings are not only beyond the pockets of disabled people but are also physically inaccessible. Goldsmith (1976) has argued that buildings are constructed by and for people who move around on two legs, not those who use sticks or wheels. In Britain, for example, between 1984 and 1989, local authorities and housing associations built some 168,665 "mainstream" homes but only 1,840 houses accessible to wheelchair users. The private house-building sector built no wheelchair-accessible homes at all (Barnes 1991).

Nor are aids and adaptations always readily obtainable. In a survey of some 700 complaints toward local authority services, RADAR (1994) quoted as reasonably common the experience of a disabled man who claimed he had been subjected to emotional blackmail over his request for a stair-lift. If his local authority supplied him with a stair-lift costing several thousand pounds, he was told, this would deny other disabled people things they need. Since the interview, he has fallen down the stairs on three occasions.

The resulting domestic and urban environment is the product of what Imrie and Wells (1993) have called "design apartheid." Because specially adapted housing tends to be built in clusters and because state or local authority housing for rent tends also to be marshaled in estates in particular quarters of towns and (inner) cities, the upshot is a segregation of various

groups or classes within a population. This is an effect that Forrest and Murie (1991) have termed social polarization.

Transport

While access to social settings may have improved generally, it remains true that in many Western societies, public transport is only partially accessible to disabled people. The United States and Sweden are leading the way here, but in Britain, only now are bus companies being forced to make new vehicles accessible. In Britain, it may take 15 years or more (as old buses are replaced) before disabled people are able to travel as freely as their nondisabled counterparts (Greater London Association of Disabled People [GLAD] 1994). In 1994, only 70 of 5,000 London buses were accessible to wheelchair users (Hansard 1994). The use of trains and other vehicles remains problematic. Only about 25 percent of the London taxi fleet is accessible, a much lower proportion of taxis than in other cities (Barnes 1991).

Welfare systems may provide some vehicles. Frequently, however, these are minibuses available only at prescribed times and on predetermined routes, and they are often restricted to supplementing other services such as day centers or lunch clubs. Even voluntary "dial-a-ride" schemes have limited coverage, and, as I point out elsewhere,

Charities . . . provide specially adapted minibuses whose use is confined principally to designated groups of disabled people characterised as being in need and deserving of help. These agencies are content to see their benefaction prominently advertised on the exteriors of the vehicles they supply. Through this act of identification, charities draw a distinction between those who use . . . philanthropic transport and those who do not. (Drake 1996a:151)

The point here is that there is a value difference not only in the form of the transport but also in the social status ascribed to clients by dint of their use of that transport.

When traditional welfare focuses on the person and when disability is defined in individual ("medical model") terms, it deals only indirectly (if at all) with environmental restrictions in movement and location. When antidiscrimination legislation is absent, these restrictions remain undealt with.

It follows that when disabled people also have less influence in government and wield little political authority, it becomes harder for them to change either the orientation of welfare or the disabling environment itself. Questions of political participation are thus of critical importance, and it is to these that I now turn.

Political Implications

Citizenship depends in large measure on political participation and on the ability to exercise at least some power with respect to deciding the prevailing norms and values of a society. In theory, welfare policies and practices, as well as those involved in the welfare professions, either could tend toward the exercise of control (by seeking to impose conformity to prevailing social and behavioral norms) or could attack the environmental structures that constrain disabled people. The latter course of action raises a dilemma for those who earn their living as welfare staff, for such a change of focus carries with it the implication that they must cede some or all of their own authority to their clients. There is often resistance to the idea of transferring—or even sharing—power.

The sort of, old contract, if you like, was, "we're the helpful, competent, able people, you give up everything to us, you're the needy ones and we'll do it for you." So it involves quite a shift in that contract and that status quo it's quite a subversive movement in a

way—it hinges on power, and the [name of authority] are a very powerful body who actually don't like a lot of the stuff that's going on. ("Elaine," in Drake 1992b:235)

Here, then, I consider some possible impacts of welfare systems on the political participation of disabled people. There are, perhaps, three main points at issue: the expression of political preferences (voting), standing for office, and serving in office (exercising political authority).

Perhaps the most immediate obstacles to exercising political influence are absence from the electoral register and a lack of access to polling stations. Fry (1987) has shown that low numbers of disabled people actually cast their votes, and both Enticott, Graham, and Lamb (1992) and Barnes (1991) have demonstrated that low turnout is exacerbated in Britain by inaccessible polling booths and because many disabled people (those in residential accommodation or hospitals) may fail to appear on the electoral register because their names have been omitted from the lists.

Voting is, in any case, a very blunt method of political participation. People who are elected to serve have a far stronger and more intimate access to power. However, a number of constitutions have historically excluded at least some portion of the disabled population from standing for office. In Britain, people are debarred if they have an incapacity due to physical or mental disability—specifically, “idiots, lunatics, and persons under the age of 21, in all of whom the law supposes a want of mental capacity or discretion” (Wollaston 1970:38-39). Schofield (1955) recorded that “deaf and dumb persons are ineligible for Parliament” (p. 83), but it is unclear whether such an opinion would be confirmed today. There are, nevertheless, impediments to the candidature of many disabled people, and even once elected, neither Parliament nor the great majority of town halls across Britain have been designed to accommodate disabled representatives. The Americans with Disabilities Act may have made matters easier for their counterparts in the United States.

Given the difficulties I have just outlined, it is not surprising that the number of disabled people elected as councilors or members of Parliament is very low. For example, only one of some 650 current members of British Parliament is a wheelchair user. Only one, a government minister, is blind, and one other, the chair of the all-party disablement group in the House of Lords, is hearing impaired. It is a sign of their absence from the political scene as a group that the few prominent disabled people who succeed become widely known and recognized. Even then, there is no guarantee that the successful few will share the aspirations of their peers. Nor would they claim to represent them.

Without political power, it has been difficult for disabled people to achieve movement in policy away from the guiding principle of “welfare” toward the principles of “citizenship” and “rights.” One response to exclusion has been “direct action.” Some disabled people have rejected welfare and have demanded equality, access, and participation, thus bringing home forcibly their arguments by civil disobedience. For example, they have carried out actions such as stopping buses in busy city centers, occupying radio or television studios, and conducting marches and demonstrations at parliaments and political headquarters (Crow 1990; Morris 1991).

CONCLUSION

In the nineteenth and early twentieth centuries, disabled people were judged against “able-bodied” social norms and requirements. Many were segregated or actually expelled from mundane society. I have shown how in Western industrialized states, this early policy of “containment” gave way in the post-World War II period to a search for other responses to disability. The construction of social services and community care policies took integration for their watchword. There came into being services based on the domestic, rather than institutional, settings. Several approaches were adopted in the search for solutions. In Sweden, an extensive welfare state came into being that provided income, social and health services, adapted

accommodation, and employment training organizations such as the AMS (Arbetsmarknadsstyrelsen). The United States, in a civil rights approach, led the way with antidiscrimination laws, such as the Americans with Disabilities Act in 1990. In Britain, welfare has been developed in a somewhat more piecemeal and fragmented way. The Disability Discrimination Act of 1995 is far weaker than its American counterpart, but new forms of resources, such as the Independent Living Fund and Disability Working Tax Credit, are aimed at enhancing the scope of disabled people's lives. In many countries, access to public transport is gradually improving and is facilitating greater independence for disabled people through access to society and to work. However, considerable social and environmental change is still required before it can be said that disabled people enjoy equal access and opportunity in modern Western societies.

Welfare states have come a long way since the days of the almshouse and the workhouse, but it remains true that disabled people still encounter restricted access to several key civil and social structures in many countries. As of this writing, for example, it is still legal in Britain to discriminate against disabled people in areas such as the military and higher education (Rights Now 1994). Equally, a common factor in advanced industrial and technological states has been the subservience of welfare to the requirements of capital. Governments have been keen to avoid undermining incentives to work, and this has meant that they have sought to ensure that incomes and other resources derived from programs of social assistance remain lower than commensurate rewards to be gained from employment. Such an approach has direct consequences for those disabled people excluded from work due either to the severity of a physiological or cognitive impairment or as a result of the contours of work itself. Other obstacles have included the absence of equal opportunity or other appropriate legislation, the lack of access to training, or the prejudicial attitudes of some employers. For whatever reasons, disabled people in general command fewer resources than their nondisabled counterparts. The upshot has been that they have been reliant on welfare structures.

I have argued that, hitherto, the prime focus of health and social service organizations has been the individual rather than the environment. Change (therapy, treatment, rehabilitation) has been located within the body or mind of the disabled person. From this perspective, we may interpret "welfare" as a mechanism formulated by and protective of prevailing (nondisabled) norms and values. Insofar as the flow of power is asymmetrical, both the concept and conduct of welfare preserve existing social and political norms from radical challenge by defining the values and condition of disabled people as being aberrant and by affirming the status quo.

Across Europe, Australasia, and North America, the response has been the growth of pressure groups run by disabled people themselves. In many countries, "disability movements" have gained considerable influence and have argued for inclusive social and physical environments and for equality of opportunity (Albrecht 1992; Campbell and Oliver 1996; Zola 1994). These calls have been accompanied by campaigns for antidiscrimination legislation.

The policy research and action that are now required must build on those innovations that have sought to liberate disabled people. For example, in Britain, innovations such as the Independent Living Fund passed some control of resources to disabled people themselves rather than to intermediaries acting on their behalf. In the United States, the Americans with Disabilities Act strengthened considerably the civil rights and legal redress available to disabled people in cases of discrimination. Clearly, then, the key research questions for the future must focus on citizenship and civil rights. How can we devise policies to remove environmental barriers and attitudinal discrimination? How best can welfare services be designed so that control rests as much (if not more) with recipients than with providers? Finally, how can we ensure that disabled people have access to the resources that are necessary for citizenship?

In the nineteenth century, states declared certain elements in their populations to be deviant and dealt with them (often very harshly) as "problem people." In the twentieth century, the paradigm shifted. People faced problems, and states inaugurated services aimed at helping these individuals to remedy or ameliorate their problems. In the twenty-first century, many nations are recognizing that (at least in part) the way we choose to build our societies (both physically and

with respect to attitudes) can cause problems for some citizens. Now the focus for change is shifting away from the individual toward the contours of what Swain et al. (1993) have called "the disabling environment."

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Welfare States and Disabled People

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