**Welfare conditionality, ethics and social care for older people in the UK: From civic rights to abandonment?**

Malcolm Carey **(**[**careym1@hope.ac.uk**](mailto:careym1@hope.ac.uk)**)**

**Liverpool Hope University**

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Malcolm Carey

School of Social Sciences

Liverpool Hope University

careym1@hope.ac.uk

**Abstract**

Welfare systems are becoming ever more conditional, with access to state support increasingly rationed via a legion of legally-defined and financially-driven restrictions and rules. Civic protection and economic rights for older citizens within Western policy systems are subsequently diminishing and continue to give way to neoliberal discursive practices which prioritise welfare activation, autonomy, participation, asset-based yet precarious self-care, the aversion of health-centred risks and much higher levels of eligibility for support. This article looks at welfare conditionality and its relationship to older people, ethics and governance within social care. By using three examples of welfare conditional reforms from the UK, it is highlighted that strains typically persist between the altruistic components of some ethical frameworks and the everyday experiences of many older people. The relative gatekeeping powers of welfare professionals and expectations placed on family members and carers have also increased, especially upon older people with higher needs and who may lack economic and cultural capital. This is despite rhetorical policy-led claims of increasing choice and control, and allowing support to be more asset-based and personalised.

**Keywords:** welfare conditionality; older people; ethics; personalisation; asset-based care.

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Welfare systems are becoming ever more conditional with access to state-funded support and benefits increasingly questioned and framed around administrative, political and legally defined rules, restrictions, expectations and incentives for recipients or ‘service users’ (Ogg, 2005; Jordan and Drakeford, 2012; Watts *et al*., 2014; Dwyer, 2019). Moderate notions of civic protection and rights for older people within Western policy systems are giving way to neoliberal governance practices which prioritise welfare activation, tightening eligibility for support and self-care. Initially expanding in the Global South throughout the 1990s in countries such as Mexico and Brazil as part of ‘human development’ projects, a ‘conditionality turn’ is increasingly established as welfare governance norm in North America, Europe, Australia and New Zealand (Watts and Fitzpatrick, 2018; Dwyer, 2019).

As an ideologically driven set of governance rationales, conditionality-based welfare integrates revised hegemonic assumptions about welfare recipients, including the elevated use of paternalistic incentives intended to reduce over dependence for citizen-subjects. In the United Kingdom (UK), enacted conditionality through legislation such as the *Welfare Reform Act*, 2012, and the adoption of policies in the UK such as *Universal Credit* and *Workfare* (Dean, 2012; Fletcher and Flint, 2018), have nevertheless provoked ethical questions about the rise of poverty, foodbanks, and destitution among marginalised populations. Broader ethical questions also remain that apparent vulnerable groups including many older adults are increasingly being abandoned by a market-led ‘post-welfare’ state (Jones and Novak, 1999; Dean, 2010; Fletcher and Flint, 2018).

Despite recognition that retirement now represents an ambiguous, diverse yet increasingly individualised and consumer-driven process, explicit debates and research around welfare conditionality have tended to limit discussion of the experiences of older people (Milton et al, 2015). Nevertheless, in the context of factors such as welfare austerity, the covid-19 pandemic and an ageing population, older people continue to be targeted for attention in relation to the relative financial cost to the state and taxpayers of any support. These dynamics stand alongside apparent generational resentment and stigma about previous welfare access and economic opportunities, which for some commentators represent part of a ‘new ageism’ (Walker, 2012; Milton et al, 2015; Anand et al, 2021).

This article looks at the relationship between conditionality policies, ethics and the care of older people: including the gradual move from favouring rights for older people towards much stronger precedence given to autonomous well-being, rational choices within markets, risk aversion and the co-produced pathologizing of needs in determining policy and welfare professional praxis. The research drew from evidence where possible to support any claims as part of the analysis. It also sought to identify and appraise relevant articles and associate source material according to their relevance to the study. As well as judge the rigour and reliability of any significant empirical studies, where possible priority was given to peer-reviewed journals or grey literature, and such studies were judged according to factors such as their sample size, trustworthiness, value and relevance. Most studies were qualitative and small-scale.

Three key UK-based conditionality-centred policy initiatives within adult social care were isolated due to their relevance and each are discussed. This is principally as they embody the ethical challenges apparent with ever increasing expectations placed upon many older adults in tandem with the further privileging of markets and the rescinding of meaningful state support. The examples include eligibility and assessments of need for receipt of social care support, followed by an analysis of the related policies of personalised and asset-based support. As part of the conclusion it is argued that welfare conditionality for older people can be viewed as representing important ideological forms of governance and control which carry numerous ethical and political consequences. Some recommendations for future policy and practice are then briefly discussed.

**Welfare conditionality and ethical paradigms**

Although intensifying in recent years, for some the principles of conditionality tied to receipt of welfare and state support for citizen-subjects carries a much longer history. Fletcher and Flint (2018), for example, argue that activation and conditionality initiatives for citizens first emerged during the early nineteenth century as a key discursive trait of the modern ‘tutelary’ or ‘therapeutic state’. De Tocqueville (2003 [1835]) had identified the tutelary state as an ideological facilitator which held the capacity to promote ‘impersonal domination’ for subjects through numerous ‘administrative, regulatory and protective governance’ powers. These enhanced the principles of liberal equality by limiting support in the form of ‘social guarantees’ and discouraging over dependency among populations (Fletcher and Flint, 2018: 772-774). Relatedly, Foucault’s understanding of governance has been utilised to stress how welfare professionals and other staff monitor and activate citizens, and how this supports liberal states endeavours to yield reflexive, ethical, and empowered citizens capable of governing themselves whilst relying much less upon state support (Cruickshank, 1999; Dean, 2010).

A notable advocate of welfare conditionality remains White (2000) who maintains that in order to receive support from the state individual citizens should be expected to fulfil ‘various responsibilities’ which the ‘state may legitimately enforce’ (White, 2000: 507). White’s understanding of ‘welfare contractualism’ is nevertheless built upon a strong notion of (multi-cultural) ‘distributive justice’ which is embodied throughout his ‘reciprocity principle’ (White, 2000: 507-509). Conditions of fair reciprocity are only validated once governments and policy makers fulfil a number of egalitarian obligations. Although engagement in paid employment plays a relatively significant part of White’s vision, he also recognises the important role of care giving and other activities such as volunteering as representing productive participation (White, 2000; Watts and Fitzpatrick, 2018).

One of the more critical accounts of conditional welfare has been provided by the diverse range of rights-based ethical frameworks. These tend to privilege citizenship-based and human rights above all else, and their core principles endure to varying degrees in various social models of ageing, critical gerontology, and the ethics of care, alongside notions of personhood and equity. Priority remains with advocacy, consciousness raising, redistributing resources to favour those in need, acknowledging forms of social exclusion, and ideally providing adequate health or social care alongside state funded benefits. Although popular with advocacy groups and many pedagogues, rights-based frameworks often lack substantive influence within government, among policy makers and can be challenging to consistently apply at street-level. They can offer a viable framework for collective resistance but some frameworks have been criticised as being built upon rather broad or even abstract notions of rights, while others may understate the impact of social class, diversity or conflict between social groups (Gilleard and Higgs, 2000; Watts and Fitzpatrick, 2018).

Among other paradigms, two very different ethical frameworks have tended to more explicitly reflect or reinforce aspects of policy. First, utilitarianism carries an egalitarian and teleological dimension with its priority given to positive outcomes, wider social welfare, or wellbeing for the many alongside utility and impartiality (Singer, 1993). Welfare conditionality is chiefly justified on the grounds of economic reasoning, including that the cost of welfare and benefits may be too great, and incentives to empower citizens can improve the wellbeing of those receiving support (Watts and Fitzpatrick, 2018). The ‘Third Way’, communitarian or ‘tough love’ branch of neoliberalism included aspects of utilitarian thinking: including, for example, the rationale that community engagement, participation, active ageing, personalisation, or even paid employment can be good for older subjects’ health and may help to alleviate loneliness, dependence and poverty (see, for example, Jordan and Jordan, 2000; Ferguson, 2007; van Dyke, 2014). A tendency towards ‘economic reductionism’ within utilitarian thinking has nevertheless been highlighted, alongside an over emphasis placed upon impartiality and scientific approaches to human welfare. This may sit alongside traditional normative or Kantian deontological reasoning advocated by many welfare professionals, which together may further promote formal rule-based discursive engagements with service users (Bauman, 1993; Singer, 1993; Kilner 1996: 125; McDermott, 2011).

Second, since the 1980s, welfare contractualism has represented an ethical framework which echoes aspects of government policy and thinking. Contractualist reasoning pivots around the notion of reciprocity, and includes a challenge to assured social rights which are replaced by mutual obligations embodying the spirit of an agreement or unseen contract between citizens and the state in which subjects are expected to always be willing and able ‘to give something back’ (Watts and Fitzpatrick, 2018: 126-129). Further privileged traits within contractualism include those of autonomy, economic independence, adhering to individual responsibility and a performative capacity to engage with consumerism, such as being able to make informed rational choices (Green, 2015). Such expectations fit with key policy narratives that promote active ageing and participation, yet as its usually built on an overtly individualistic model, contractualism can neglect the negative consequences of poverty and inequality among older citizens, and understate other crucial issues effecting older people outside any ethical bubble. These may include the constraining impact of power, such as potential dominance in decision making of welfare professionals, alongside wider implications of policy, including structured dependency and inequality for marginalized user or carer groups (Jones and Novak, 1999; Estes et al, 2003).

**Quasi-markets, eligibility, and risk**

The first policy related example of conditionality focuses on the rapid expansion of quasi-markets of care during the 1990s and beyond in the UK, and which has led to a significant relative reduction of direct state-support for older people through services and care (Harris, 2003; Jordan and Drakeford, 2012). The transformation of welfare professionals such as social workers into ‘care managers’ led to a move away from direct personal support to a focus on the commissioning and coordination of an increasingly fragmented network of chiefly private sector run services (Harris, 2003; Kemshall, 2010; Ray, 2014). As in health care with the role of GPs and other medics in limiting interventions through gatekeeping and the rationing of treatments (Pollock, 2004), the undertaking of assessments of needs by social workers has since remained a bureaucratic gatekeeping mechanism. In particular, the tool of assessment has ultimately been driven by a need to ration resources and manage eligibility, rather than promote user choice or control (Kemshall, 2010). The rationing of care for ‘service users’ later intensified further with austerity measures linked to the financial crisis in 2008. For example, almost half of councils provided care for older people with ‘moderate’ needs in 2005/6 in England, but from between 2005 and 2014 this had dropped to 13 per cent of councils in England providing such support. Between 2019 and 2020, local authorities in Britain received over 30,000 requests from family members for social care support for older relatives which did not lead to any services being provided (Kings Fund, 2021a). Alongside the needs of an ageing population, evidence suggests that adults including those in employment *under* 65 are increasingly requiring more social care support, and a growing proportion of local authorities in the UK now prioritise younger adult groups for funded support (Kings Fund, 2021a; Kings Fund, 2021b).

Although at first glance market-based policies within social care concur with some of the principles of contractual ethics, closer examination suggests that many reforms contradict vital aspects of their intended remit as part of a business discourse. Heugens et al (2006), for example, argue that contractualism has a rich history dating back to Ancient Greece, and is traditionally built on the ‘intuitively appealing idea’ that economic engagements and associations should be ‘guided and constrained only by those norms and institutions that freely consenting agents could, and possibly would, agree to if they had the choice’ (Heugens et al, 2006: 393). Other altruistic traits attached to contractualism include those of openly sharing information, maintaining good faith, reliability and establishing a reputational-bond between service providers and consumers in the market place (Bernstein, 1992; Heugens et al, 2006). Due to limited resources local authorities have been forced to engage in activities such as purchasing ‘block contracts’ from a diminishing number of suppliers to save money (Harris, 2003; Scourfield, 2007; Lymbery, 2012). Subsequently, user choice held within a market state or ‘post-welfare’ discourse has become extremely limited for many older people, alongside a lack of availability of information and advice. A sense of reliability and trust between ever more risk averse care managers and service users with higher-level needs is often also severely compromised by the prevalence of utilitarian and bureaucratic procedures during any brief and formal engagements (Harris, 2003; Hall and Scragg, 2012; Ray, 2014).

Ethical tensions have escalated in other areas. The growth of a business of social care, for example, has meant that crucial areas of support for older people such as residential and nursing care have become prime sites for investment by international venture capitalists. Jordan and Drakeford (2012: 89), for example, highlight the appeal of publicly subsidised ventures in offering a rich and accessible source of equity to companies such as Blackstone which had previously shown no interest in the care of older adults:

It is important to be clear that such equity buyouts are motivated by one thing only – the prospect of rapid and rising profits. Blackstone was not an organisation driven by an interest in social welfare. Later in the same week that it acquired [Surry-based] NHP [for £564 million], it also bought a French cinema group, a German chemicals company and the Dutch telephone directory supplier VNU. Residential care was simply another commodity from which profit might be extracted, only this time with the added advantage that such profits were being supplied by the public purse.

Alongside escalating charges and costs imposed by companies such as Blackstone, regular changes in the ownership and control of care homes and other support services has often caused considerable uncertainty and stress for many older residents and their families (Scourfield, 2007). The *Health and Social Care Act*, 2012, and the *Care Act*, 2014, have further extended competition and privatisation within social care (Glynos et al, 2015: 63-64). An under resourced and deeply fragmented ‘social work business’ has persevered, within which contact between care managers and older ‘service users’ remains ever more formal, brief and detached. Consequentially, a fundamental condition of professional engagement within adult social care has remained an assumption that older adults or their family members be resilient, draw from their strengths, and are capable of coping with very limited or no support (Harris, 2003; Ferguson, 2007; Ray, 2014).

A range of additional factors including demographic pressures and increasing conditions tied to receipt of welfare has also meant that expectations placed upon family members and other carers to support older people have subsequently intensified, leading to predicted ‘devastating results for families and the health and social care system’(Ogg, 2005; Buckner and Yeandle, 2015: 6). Other ideological dynamics have again impacted upon conditionality within adult care. Attention has been drawn to the ways by which community care market-based reforms fit with a wider ‘risk discourse’ which extends the deontological management of rules in relation to finances and human risk whilst nevertheless marginalising other priorities such as those which prioritise the substantive rights of older people (Kemshall, 2002; Webb, 2006). Based on priority given to a narrow focus upon rationing resources, risk and medically-framed needs, many older people can be placed at further jeopardy due to factors such an expansion of low paid and transient support staff who not uncommonly receive limited training from their employers and spend only very brief periods of time with users in their home (Dustin, 2007; Kings Fund, 2021a). Recently the King’s Fund has again expressed concerns about the overall lack of adequate social care provision, the quality of any formal care and the consequences this may carry:

The social care system is not fit for purpose and is failing the people who rely on it, with [high levels of unmet need and providers struggling to deliver the quality of care](https://www.kingsfund.org.uk/publications/social-care-360) that older and disabled people have a right to expect. These combine to place great pressures on families and carers. (Kings Fund, 2021a: 1)

Limited resources have subsequently led to priority often being placed on the provision of a minimum degree of physical care within fragmented social care sectors, which often sits alongside erratic levels of support as part of ‘safeguarding’ among the oldest old with higher-level needs (Hall and Scragg, 2012; Moore, 2020). Some evidence also suggests that the abuse of older people living in UK care homes ‘remains both widespread and entrenched’, yet only a ‘fraction’ of any such abuse is reported to appropriate authorities (Moore, 2020: 35).

Through a strong focus placed upon quantifying rather than alleviating need or risks, welfare conditionality may not untypically restrict and control the possible interventions available, and subsequently alter discursively-informed attitudes towards service users. Tomkow (2018; 2019), for example, has highlighted the role of a risk discourse in managing and displacing the care of ‘fragile’ older people, including those who seek asylum, which itself leads to new forms of stigma for aged-othered patients. Within the generally costlier domain of health care, the priority within welfare it seems is to ‘identify and mitigate risk and disorder through medical prevention strategies which [represent] forms of social control’ (Tomkow, 2019: 66). Here, bureaucratic classification systems - such as those embodied within a risk discourse that is carefully controlled by medical and health care professionals – can reconfigure ‘fragility’ within old age at the level of discursive consciousness as symbolising an ontological hazard, especially in terms of representing a potentially significant financial cost, threat, or relative burden to wider society.

**Personalisation and self-directed care for older adults**

Despite significant challenges relating to the marketisation of social care and other welfare sectors, the policy of personalisation initially appeared to bolster policy makers’ promotion of older peoples’ informed rights, control, and choice. Rather than welfare professionals continuing to dominate decision-making for the management of formal care, users or their informal carers would be encouraged to directly manage and ideally arrange any funded support from a personal budget (Barnes et al, 2017). The option of older people undertaking self-assessments also stood out as a relatively unique policy mandate. Initially it was assumed that family members, third-sector staff or welfare professionals could assist if this were necessary and agreed with service users or their carers (Glendinning et al, 2008; Lymbery, 2012). The need to ‘personalise’ services were justified by the Labour government throughout the 2000s (and ever since by Coalition and Conservative governments) to challenge the monopoly of state-run health and social care services, which were criticised as institutionalised, unreliable and dominated by professional or managerial agendas (Lloyd, 2010).

Despite initial support from professional groups and some older adults, personalisation and person-centred care have allowed the principle of welfare conditionality to further intensify. Alongside the continued requirement for older people to meet any eligibility for provision relating to needs (and which would still be controlled by welfare professionals), expectations placed upon service users and any carers grew despite no additional resources being provided to support the policy (Lloyd, 2010; Lymbery, 2012; Barnes et al, 2017). As early critics, Ferguson (2007) and Lloyd (2010) argued that personalisation fulfilled ever more ideological objectives. These included a wish to further expand private sector care services, alongside other businesses, and increase the responsibilities of family members and users themselves. For example, Ferguson notes that as part of personalisation the privatized holding company *British Telecom* became heavily involved in an associated reliance upon new technology to operate social work call centres. Through such technology contact between social workers and service users was minimised, and eligibility and access to market state support more rigorously controlled. Such service provision also placed older people with a learning disability, mental health need or communication impairment at a significant disadvantage in narrating any conditions or circumstantial evidence to access care. A wider ideological remit of disseminating risk and responsibility from the state to the older person as user (alongside family members and possibly friends and neighbours) were deemed further important objectives: which together embodied the ‘privatisation of risk’ under the guise of endorsing altruistic traits such as co-production, choice and independent living (Ferguson, 2007: 388-392). Moreover, the impact of poverty and inequality upon older people or their family members were largely ignored by policy makers, despite evidence that more educated users and families tended to navigate any responsibilities or conditions to access support better as part of personalised care (Ferguson, 2007; Feltoe and Orellana, 2013).

An in-depth evaluation of thirteen separate pilot schemes was undertaken in England by Glendinning and colleagues (2008). These sites were each to fulfil key requirements which included the management of individual budgets by service users alongside the facilitation of a means of empowering users ‘to play a greater role in the assessment of their needs’ (Glendinning *et al*, 2008: 27). However, predicting what would soon become an all too familiar trend which reverberated in numerous later evaluations, notable disparities quickly emerged between the experiences of older people and many other user groups. These included that service provider driven arrangements from a relatively limited array of companies involved in care often stifled flexibility and any meaningful choice of provision for most older people. Moreover, any conditional needs recognised through funding following professional assessments for older adults tended to be narrower than for most other demographic groups, and less financial support was typically made available by local authorities. In addition, long established findings that many older people turn to social services and social care support as a last resort (and often with deep apprehension) were again confirmed. Under such circumstances, the evidence suggested that being placed under pressure to self-manage any support was interpreted as a ‘burden’ which was often stressful, and not untypically led to feelings of intense anxiety. Perhaps unsurprisingly the study also discovered that being in receipt of a personal budget led to lower levels of psychological wellbeing for most older people (Glendinning *et al*, 2008: 24-29).

Later studies have also noted that a personal budget often increases older people’s dependence upon their carers or family, which can again lead to further risks alongside feelings of anxiety or depression (for example, Feltoe and Orellana, 2013). Other critics highlighted that official documentation has reiterated references to the growth of a dependent ageing population, as well as the seemingly enduring and escalating financial cost of providing support (Lymbery, 2012). *Putting People First* (Department of Health, 2007), and the *Care Act, 2014*, for example, conveyed the apparent strains of a rapidly ageing population, and maintained an urgent need to address options for the funding of health and social care systems. In 2010, the policy document *A Vision for Adult Social Care*, reiterated that personalisation was central to government policy yet added that care for older adults must be ‘about reinforcing personal and community resilience, reciprocity and responsibility, to prevent and postpone dependency and promote greater independence and choice’ (Department of Health, 2010: 5).

While highlighting some of these points and others, Lloyd (2010) argues that the feminist and ‘justice turn’ inspired Ethics of Care offers an ideal holistic framework through which the nuances of the giving and receiving of personalised care for older people can be better understood. This includes its capacity to ‘place the perspectives of those who are in need of care centre-stage’, and focus on ‘the many ways in which dependency is experienced at this stage of the life course’ (Lloyd, 2010: 198). As Lloyd herself acknowledges, not everyone agrees however. In examining numerous debates regarding the fourth age, Higgs and Gilleard (2015: 107-108) stress the Ethics of Care’s inability to fully accommodate the nuances of care giving and, in particular, the unequal power relations which can quickly form between numerous fourth age demographic groups and their care givers. Relatedly, they point to an often unavoidable ‘parent/child template’ not uncommonly embodied in much care for older people with high level needs, and which may be further denied if we insist on assuming and universally privileging idealised support and compassionate care above other types of response. Taking a different stance, some disability rights campaigners have argued that the Ethics of Care can presume or overstate dependency in its privileging of the importance of female carers (Lloyd, 2010: 198). Concerns have also been raised that any associated humanist-inspired support of virtuous social care embedded within the rights-based Ethics of Care are perhaps also unlikely to maintain substantive ethical and moral traction within the resource-starved, highly rationalised and bureaucratic domains of crisis-orientated and risk-focused social work (Meagher and Parton, 2004).

As part of a critical appraisal for *Age UK* of numerous empirical studies concerning the impact of personal budgets relating to personalisation policies effecting older people, Feltoe and Orellana (2013) again highlight the significant number of gaps and inconsistencies regarding the provision of social care services. These include differences in terms of the availability and choice to access a personal budget or not geographically across different regions and local authorities in England. Older people tended to again be much less likely than other user groups such as younger disabled adults to be offered a personal budget, and priority was almost exclusively given to the provision of essential physical care rather than support to pursue personal or social interests. This is despite each of these identity or emotionally related needs being acknowledged as often crucial to the wellbeing of many groups of older people (Gilleard and Higgs, 2000; Green, 2015). Following interviews and focus group meetings, Irvine et al (2017) sought to analyze the impact of personalisation on twenty-six people, including thirteen older adults (60 years or older), from Chinese backgrounds who lived in England. They discovered that due to a crucial lack of information, opportunities to meaningfully engage or appropriate culturally sensitive support, personalisation policies regularly reinforced long established forms of exclusion for many of the minority ethnic participants interviewed.

**Asset-based care, ethics and abandonment?**

More recently policy makers, local authorities and professional groups in the UK and other countries have been keen to promote asset-based care. This agenda aims to focus attention upon local peoples’ strengths, skills, knowledge, resilience and social capital within and alongside communities (Foot and Hopkins, 2010). Although asset-based approaches initially emerged in health care as part of a concerted attempt by professionals to stimulate preventative support on behalf of patients, it has since been extended and promoted more widely including in social care and other sectors such as housing welfare (Foot and Hopkins, 2010; Montgomerie and Budenbender, 2015). In a not too dissimilar vein to personalisation policy narratives, special interest has been given to moving away from traditional deficit-based approaches, which are criticised as concentrating on overtly negative traits and characteristics for users, patients and community members. This notably includes a seemingly biased focus given to illness, deprivation, and apparent ‘social problems’ in order to meet professionally determined ‘needs’. This can lead to communities’ feeling ‘disempowered and dependent’ whilst encouraging people to become ‘passive recipients of services rather than active agents in their own and their families’ lives’ (Foot and Hopkins, 2010: 7). Rather than instinctively offer formal care or other direct support as part of such a deficit model, welfare agencies, professionals, support staff and volunteers should instead utilise asset-based technologies and instruments to map community-based strengths, and empower older people and others to draw from their many assets to reshape the ageing self and support one another.

In reinforcing further key condition-centred drivers embroidered within personalisation narratives and other initiatives, a fundamental part of asset-based care has remained co-production and service user or citizen-led participation. As part of a wider agenda to engage communities, decision making about how to effectively utilise community-based assets is intended to be shared between welfare professionals, support workers and pro-active stakeholders, which can be utilised to meaningfully sustain health and well-being (Ziegler and Scharf, 2014). Despite largely achieving general popularity with professional groups and many pedagogues alike - including due to the potential of participative approaches to extend the rights of service users - scepticism and informed critique still persist. For example, questions remain about a lack of clarity regarding what co-production or participation actually constitutes in practice, and welfare and other professionals tend to still lead many initiatives and dominate key decision making. This includes as part of participative projects within the NHS, local authorities and voluntary organisations (Cowden and Singh, 2007; Scourfield, 2015). Apprehension also remains about the use of participative and engagement discourses to extend supply-led and free market provisions further, such as when a ‘quasi-customer’ or managerial model of co-production is promoted or invariably ensues, alongside the ongoing retreat (and escalating financial cost) of formal care. Indeed, any meaningful substantive gains for service users following any participation have proven difficult to evidence, and some concerns have been raised that participation may be as much about validating professionalism and markets of care as benefiting older users or their carers (for example, Cowden and Singh, 2007; Carey, 2019).

Asset-based interventions have largely been embraced by the devolved Scottish government, including as a resource to confront health inequalities and social exclusion, which has led to the burgeoning of projects in cities such as Glasgow (Friedli, 2013; Glasgow Centre for Population Health, 2017). The Glasgow Centre for Population Health undertook a city-wide evaluation of nine services which utilised an asset-based approach, and included interviews with ten key strategic leaders involved in the projects. Although there was ‘broad support’ for the initiatives, other notable findings highlighted tensions between service providers and community-based users, and some scepticism on behalf of strategic leaders that initiatives were offering nothing new and were instead being used for other political purposes:

The term [asset-based] was felt to create a divide between service providers and people supported by services, which asset-based approaches themselves actually seek to diminish. Although the language of assets was seen as new and unfamiliar this sat in sharp contrast to the practice of asset-based approaches, which were recognised by others to be long-established. Interviewees spoke of scepticism that they feel exists about the introduction and applicability of asset-based approaches within service settings, particularly in terms of taking such approaches in an attempt to mask reductions in funding for services. (Glasgow Centre for Population Health, 2017: 11).

When looking at the growth of asset-based care for older people, Daly and Westwood (2017) highlight that since the 1990s assessments of needs undertaken in the UK for older people by social workers have looked to identify service users’ strengths and engage with any available informal support provided, including community-based. As well as ideologically repackage what has already been provided for some time, they add that asset-based projects also fail to meaningfully engage with paramount macro-structural issues within communities, and largely ignore the frequently pivotal role of power disparities between welfare employees and service users within the domain of formal care. This is whilst offering conditionality-based prescriptions that are ‘in essence located at the individual and community levels’ (Daly and Westwood, 2017: 10). As part of an appraisal of the role of public health in supporting an asset-based discourse in the UK, Friedli (2013) notes the policies unrealistic conditional expectations placed on often disenfranchised local people, and its persistent incapacity to meaningfully address the ‘abandonment of areas of deprivation by both the market and the state’ (Friedli, 2013: 10). Moreover, alongside economic abandonment, Friedli adds that there persists an over reliance upon therapeutic and behavioral solutions at an individual level as part of asset-based welfare professional interventions. In particular, the asset movement increasingly appears to ignore social rights in favour of a pathological focus placed upon stakeholder ‘health behaviors’, with attention instead given to a narrow range of attributes which include positive thinking, aspirations, resilience, self-reliance and self-efficacy (Friedli, 2013: 9-13). Indeed, the many conditions now attached to accessing acutely finite welfare-related support for service users can also now include an in-depth psychological and moral evaluation of any older citizen’s worth, alongside expectations to reconsider one’s behavior, values, strengths and purpose in life.

**Conclusions**

Much of the evidence from social care and social work suggests that welfare conditionality for older adults represents as active an ideological force as for other targeted demographic groups including lone mothers and unemployed adults. This appears more acute for older people with higher level social care needs as they are more likely to require state funded support, and other established exclusionary factors such as social class or ethnicity appear to often play an important role in influencing the impact of conditionality. Strains can persist between the altruistic components of some ethical frameworks, including rights based and contractual ethical paradigms, and the everyday experiences of many older people targeted by welfare conditional reforms.Nevertheless, in echoing Althusser’s (2001) materialist-driven claim that ideology represents a system of symbolic representations - and what Zizek (2008: 13) has interpreted as the ‘inexorable “abstract”, spectral logic of capital that determines what goes on in social reality’ - conditionality for older subjects can often be presented as fair, supportive, empowering and as promoting engagement, well-being, and autonomy. Nevertheless, this is also whilst endeavouring to discourage and limit the cost of welfare dependency. According to some commentators, subsequent outcomes including the erosion of welfare and social rights, alongside the meeting of ever more obligations and duties for older people and their dependents or family, are, it seems, at least in part, discursively displaced (Jones and Novak, 1999; Dean, 2010; Feltoe and Orellana, 2013). Further ideological outcomes through policy (and elements of welfare professional praxis) have included the encouragement of endeavours to extend eligibility for support, promote participation and an active engagement with local communities, while extending (inequitable and fragmented) markets of care. This is alongside structurally-induced or other challenges not untypically marginalised as priority by policy makers and at least some professional gatekeepers.

For many older people, welfare conditionality may therefore often be viewed as representing an important and increasingly powerful ideological instrument. Although offering the potential for positive support welfare conditionality within social care increasingly enacts ever more expectations and responsibilities, whilst elevating levels of professional control, as well as often providing a restricted number of positive ethical outcomes for many older adults.

Based on the available evidence and discussion, some brief examples of possible ways forward for improved provisions for older people would almost certainly need to include the availability of sustainable, fair and adequate funding for social care. Relatedly, better financial support for a meaningful rights-based reinterpretation of policies such as personalisation and asset-based care would again appear a reasonable ethical outcome, and indeed such points have tended to be reiterated by a number of advocacy and professional groups (for example, Feltoe and Orellana, 2013; Daly and Westwood, 2017; Kings Fund, 2021a). A purposeful role for social workers beyond managing resources, markets and risk in support of families and service users who seek to access personal budgets again appears reasonable (Dustin, 2007; Lymbery, 2012; Friedli, 2013). Finally, for an ageing population, an underlining principle of offering purposeful support, advocacy, guidance, altruistic care and perhaps even more ambitiously degrees of ownership and control of services – as opposed to rigidly supervising welfare conditionality and resources - may reflect a policy which could more likely be deemed ethical.

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