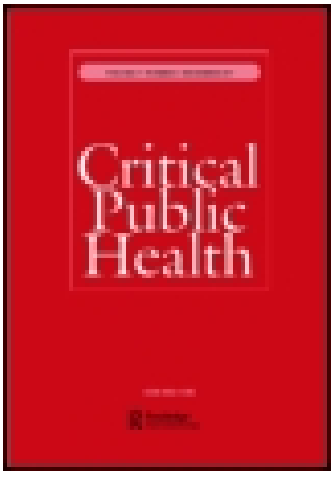

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The powerful pull of policy targeting: examining residualisation in Australia

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The powerful pull of policy targeting: examining residualisation in Australia

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Increasingly, researchers are arguing that there is a need to 'act universally' in order to address social and health inequalities. While, in theory, universal approaches to tackling inequalities are valuable, putting them into practice has proved to be much more difficult. Debates between universal and targeted approaches continue, both in the public health literature and social policy (a field with significant bearing on population health). These debates revolve around ideology and the intuitive appeal of targeting. In this paper, we explore how these ideologies and logics play out in the design and implementation of policy, using the Australian Social Inclusion Agenda as a case study. Based on our analysis, we suggest that a more dialogic approach to working with policy-makers is required in order to promote reflection on broader tendencies in the design and implementation of policies.

Keywords: policy targeting; universalism; social policy; social determinants of health

Introduction and background

Increasingly, researchers are arguing that there is a need to 'act universally' in order to address the social determinants of health. Most recently, the Marmot Review of Health Inequalities compiled an impressive body of evidence on the social determinants of health and health inequalities (Marmot, 2010). In order to address inequalities, the review's authors called for 'proportionate universalism'. Here, services are delivered universally, but different groups across the 'social gradient' are provided additional support according to need (i.e. a universal approach, supported by positive selectivism, where the needs of different groups are still dealt with). Population modelling suggests that this approach maximises gains across the population (Brennenstuhl, Quesnel-Vallee, & McDonough, 2012). Universal approaches are supported by research into the impact of different welfare state regimes on the health of populations, which indicates that social democratic welfare states, which favour universal policies, perform better on key health indicators (such as infant mortality rates) than liberal welfare state regimes, which utilise more 'targeted' policies (Coburn, 2004). A recent systematic review of the welfare typology research has found sufficient evidence that welfare states which have more universal services produce better health outcomes (Brennenstuhl et al., 2012). Indeed, universalistic policy measures are framed as a precondition for equity (along

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with approaches to address differences in need) and, therefore, improvements in health; 'in areas where universal programmes exist, institutional social policy decreases inequality by making it possible for lower socio-economic strata to enjoy roughly the same standard as other groups' (Korpi & Palme, 1998, p. 661).

In public health, these types of arguments stretch back to the mid-nineteenth century. Most famously, Geoffrey Rose (2001) argued that high-risk (or targeted) approaches are – by definition – palliative (McLaren, McIntyre, & Kirkpatrick, 2010; Rose, 2001). As a result, Rose argued that interventions need to be indefinite because risks are managed, not prevented (i.e. no efforts are placed into preventing those higher up the social gradient from slipping into the bottom social stratum).

Yet, gaining support for universal approaches and their adoption has proved challenging; targeting has a 'powerful' pull (McLaren & McIntyre, 2013). For example, the response to the Marmot review has demonstrated that focusing attention and efforts 'across the social gradient' is divisive; Canning and Bowser responded that: '… a better goal is to improve health, income, and socio-economic outcomes for the most disadvantaged in society, and that the best way to do this is direct health interventions …' (Canning & Bowser, 2010, p. 1223). These debates continue despite compelling evidence that the concentration of resources and interventions on the most needy does not reduce inequality and are often limited in their ability to improve the health of individual groups (Costa Font, Hernández-Quevedo, & McGuire, 2011; Frohlich & Potvin, 2008; McLoone, 2001; Tunstall & Lupton, 2003). For example, in comparing different types of interventions, Chokshi and Farley (2012) found that interventions that tackle structural determinants of health are more effective than targeted approaches, while McLoone has shown that area-based targeting misses more poor people than it includes (McLoone, 2001).

Tensions between universal and targeted approaches have also been a perennial issue in social policy, a field which has a significant impact on the social determinants of health (McLaren & McIntyre, 2013). As argued by Titmuss in the 1950s, in any discussion of the welfare state, 'much of the argument revolves around the principles and objectives of universalist social services and selective social services' (Titmuss, 1958). In social policy, the preference towards targeted approaches is referred to as the 'residualisation' of policies, whereby government support for the poor is a last resort. This is different from approaches like proportionate universalism which use positive selectivism, where different groups may be treated differently within a universal framework.

Preferences towards targeted approaches stem from a combination of the intuitive appeal of targeting and the now dominant discourses of neoliberalism, which favour residual provision of services and support by governments (Chung & Muntaner, 2007; McLaren & McIntyre, 2013). Despite this, little is known about how these intuitive logics and ideologies 'play out' in the design and implementation of specific policies.

New policies are not implemented in a vacuum; they are introduced into existing belief systems, norms and practices. The welfare state refers to 'what governments do … with the intention of improving the welfare or happiness of people' (Bessant, Watts, Dalton, & Smyth, 2006, p. 1). While some political scientists (for example, Esping-Anderson, 1990) believe that this is the truest – or most ideal – definition of the welfare state, it is not the most common. Often, 'welfare state' is used to describe the *minimum* level of government-led provisions provided to those experiencing poverty or disadvantage (Bryson, 1992). In other words, 'welfare state' is used largely to refer to the provision of *welfare relief*. In this paper, we use 'welfare state' in its broadest sense.

The first traces of the Australian welfare state emerged after Federation, with the introduction of the 'basic wage' and old-age pension. Pre-Federation, approximately

20% of the Australian population lived in poverty (Mendes, 2008). As governments came to realise that poverty was a product of social and economic conditions – rather than individual behaviour – they began to take up a greater interventionist role to address it (Garton, 1990). Thus, the Australian welfare state has its roots in 'welfare relief', as opposed to what Titmuss called an 'institutional welfare state' (Titmuss, 1958). Titmuss (1958) defined institutional welfare states as revolving around the principles and objectives of universalist social services. Institutional welfare states, such as the Scandinavian states, provide for the entire population, utilising universal support and services (Esping-Anderson, 1990). Australia, however, favours residual and means-tested policy, which comes into play when other forms of welfare (e.g. family and voluntary) fail (Reynolds, 2000). That is a concern for delivering 'welfare relief' or the 'part' of the welfare state that provides for those most in need. This is encapsulated by the term 'residual approach to the welfare state'.

Whilst Australia is generally classified as a liberal welfare state (along with the US, Britain and Canada), it has always been considered an aberration in this class (Bessant et al., 2006; Castles, 1985). Indeed, McMahon (2000) notes that there has never been a consensus over the Australian welfare state and its classification. Moreover, like other liberal welfare states (such as Canada and the US), it has always been subject to conflict between competing ideologies and philosophies about the role of government in society (McMahon, 2000). Castles (1985) famously referred to the Australian welfare state as the 'wage earners' welfare state, arguing that much Australian social policy was in fact created through the industrial relations system. He argued that the Australian Labor party was less progressive than its British and European counterparts, pursuing only a modest number of welfare state policies (Castles, 1985). Consistent with this, Esping-Anderson (1990) considered Australia to have never fully embraced the 'universalistic idea'. Despite some efforts to provide universal services (i.e. health care), Australian social policy utilises an almost unprecedented level of means-testing and targeting to the poor (McMahon, 2000).

While Australia does have a number of important universal services, as a whole means-testing and residual services are the norm. Indeed, some of Australia's most notable universal services have been under political attack since their adoption, including Medicare which was partially dissembled and undermined in the 1990s by both the Hawke and Howard Governments and has come under attack again from the current Abbott Government (for a comprehensive history of Medicare, see Boxall & Gillespie, 2013). Similarly, public education in Australia, while universal, has been the topic of considerable debate and has been found to be in need of significant reform due to a systematic underinvestment for close to two decades, while government support of private education has grown substantially (Commonwealth of Australia, 2010). More recently, the National Disability Scheme has been lauded as a universal approach. Yet, at the time of writing, it had not been implemented and considerable debate existed around the government's capacity and commitment to reform on this scale (Hurst, 2013). Moreover, in the strictest sense, the scheme is not universal, with different levels of support provided on the basis of perceived need (Carey & Crammond, 2014b). Both schemes demonstrate that even where universal approaches are adopted within liberal welfare state regimes, they are subject to sustained political debate and periodic attacks.

It is sometimes argued that the Australian welfare state only truly developed beyond basic welfare relief in the 1970s, under the progressive Whitlam Government (McMahon, 2000). The Whitlam years saw the greatest period of legislative activity regarding welfare in Australia's history. Whitlam ascribed to the idea of 'the good society', where the

welfare state was recast in terms of a greater responsibility of governments to their citizens, rather than the provision of a minimal social safety net (Beilharz, Considine, & Watts, 1992). Macintyre (1986) argues that Whitlam's reforms constitute the most substantial exercise of social democracy in Australia's history, increasing the role of government to promote a more equitable society (McIntyre, 1986).

Yet, the Whitlam years are generally considered an aberration in the history of Australian social policy (Mendes, 2008). Elected in 1976, the incoming Fraser Government once again favoured welfare programs that promoted independence and self-reliance, representing a return to residual approaches. The more institutional welfare programs of the 1970s were subsequently reduced in the economic reforms of the 1980s and 1990s: the early 1980s marked the rise of neoliberalism or economic rationalism internationally and within both sides of Australian politics, resulting in a retreat from universal policies (Sawer, 1984).

Drawing on global trends towards neoliberal policy, the macroeconomic and industrial reforms of the Hawke and Keating Governments in the 1990s created an expansion of privatisation, deregulation and free-market policies, shifting attention back towards a residual approach. The subsequent Howard Government expanded the macroeconomic reforms of the Hawke and Keating Governments (Bessant et al., 2006). This government was dominated by two ideological tendencies: a neoliberal concern for reduced government intervention in the market and a social conservative concern for bolstering traditional institutions (i.e. 'the family'). While expanding social spending overall (particularly targeting the middle classes), the Howard Government was distinctive in its tight bureaucratic control and surveillance of those receiving welfare relief (McMahon, 2000).

In 2007, the newly elected Labor Government claimed to see a strong interventionist role for government, with a focus on providing strong social and public services to improve the well-being of all Australians, articulated by their reform agenda – the Social Inclusion Agenda (SIA) (Carey, Riley, & Crammond, 2012). This indicated a more expansive vision of the welfare state and the possibility of a shift away from residualisation (Rudd, 2009).

In this paper, we explore the implementation experiences of the SIA, which provides a case study of the barriers to universalistic approaches to the social determinants of health within liberal welfare states. The SIA (2007–2013) was a major social policy reform agenda, which aimed to reduce social, economic and health inequalities (Carey et al., 2012; Commonwealth of Australia, 2011). Our analysis highlights the ways in which residual approaches form historically entrenched ways of 'knowing and doing', shaping how policies are implemented.

Methods

The aim of the study was to investigate the implementation experiences of the SIA amongst government and non-government policy actors charged with its implementation. In-depth case study analysis was undertaken with two non-governmental organisations, utilising participant observation and semi-structured interviewing. This was followed by semi-structured interviews with key policy actors within government (for full study protocol see Carey, 2010).

Through policy documentation, three government departments were identified that were principally responsible for the design and/or implementation of the SIA. Snowball sampling was conducted in order to identify participants. Individuals were sought who: (a) had been directly involved in determining the vision and scope of the agenda or (b) had been in a position to influence its implementation in terms of achieving change

within government. Snowball sampling continued until interviewees were unable to suggest other potential participants or began to nominate individuals already interviewed. Six semi-structured interviews were conducted in total across the three major departments charged with implementing the SIA. Participants ranged from current and past deputy departmental secretaries to directors of units and senior advisors (e.g. to the prime minister). Given the small number of individuals able to comment on the agenda and the very senior nature of the participants, combined with the fact that interviewees began to nominate individuals already interviewed, one can infer that the 'population' of potential participants was largely exhausted.

Semi-structured interviews were recorded and transcribed verbatim. Themes covered in the interviews included: the vision and scope of the SIA; the implementation of the SIA within government; and the effectiveness of new processes and structures put in place to aid the implementation of the agenda. 'Like' data were grouped together to form categories and subcategories. These categories were gradually developed into themes, by linking and drawing connections between initial categories and hypothesising about consequences and likely explanations for the appearance of certain phenomena (Strauss, 1987). Selective coding was then carried out, whereby transcripts were revisited with the explicit intent of finding further linkages and connections between phenomena and the core themes being developed.

Findings: the pull of residualisation – implementing the Australian SIA

As a radical social policy reform agenda, the SIA had the potential to make a significant contribution to health. Social exclusion focuses attention on the structures and processes in society that create unequal access to resources, generate differential quality of membership in society and produce unequal outcomes – all of which contribute to the health and well-being of individuals and communities (Galabuzi, 2004). As outlined by Carey, Riley and Crammond (2012), the SIA has the potential to contribute to public health on three levels: by delivering more effective and efficient goods and services to citizens, particularly those who are marginalised or disadvantaged, through promoting social participation and social cohesion and most significantly, through addressing structural inequality through the provision of more universal services. Moreover, as Raphael (2003) has argued, social exclusion is a significant social determinant of health in itself (Raphael, 2003).

In social policy terms, social inclusion is thought to draw attention to both the process and outcomes of inequality. Consistent with this, the SIA was aimed at improving the overall functioning of the welfare state by building on and extending universal services in order to make them more flexible, able to meet a greater range of needs and, in turn, more likely to address exclusionary social structures (Commonwealth of Australia, 2009). In some ways, this is not dissimilar to emerging concepts of proportionate universalism, emphasising both universalism and diversity (Marmot, 2010). Under the SIA, the government hoped to '… build a nation in which all Australians have the opportunity and support they need to participate fully in the nation's economic and community life, develop their own potential and be treated with dignity and respect' (Commonwealth of Australia, 2009, p. 2).

As an agenda aimed at improving the well-being of *all* Australians, the SIA applies to all policies, including those 'policies designed to meet the needs of the whole population and those that are focused on meeting the needs of particularly disadvantaged groups' (Commonwealth of Australia, 2009, p. 1). As a plan for welfare

state strengthening, the agenda operates across all major policy areas, including education, employment, health, and through infrastructure, such as law, 'financials' and economic services (Commonwealth of Australia, 2009).

Hence, the vision of the SIA was a universal, or institutional approach, to the welfare state, with additional resources targeted towards the poor:

> Progress will be built on improved universal services like education and health that better meet the needs of all Australians, particularly those who most need the services but may have greatest difficulty accessing them. (Commonwealth of Australia, 2011, p. 65)

The SIA rested on existing universal services, such as health care and public education, as well as the government's broader program of reform (For more information see (Carey et al., 2012). The agenda was clearly aimed at the whole population:

> These actions to support a stronger and fairer Australia have been designed to increase the number of Australians who are able to benefit from the opportunities created by a changing economy and society. (Commonwealth of Australia, 2011, p. 16).

As such, the rhetoric of the SIA constituted a significant deviation from historical approaches to the welfare state. The SIA needed to overcome historically embedded beliefs about the role of the state in providing for its citizens (i.e. extensive care for the well-being of all citizens or welfare relief). This proved to be a challenge for the implementation of the SIA.

In discussing the implementation of the SIA, policy-makers described challenges associated with scale. Here, the targeted approach is framed as being a more practical means of approaching policy solutions compared to the 'big vision' of universal initatives:

> It provides a strong motivator for many of the parliamentary MPs, but it's too big for any one department to say, 'well I'm going to tackle that big vision'. [Participant 6]

> Whenever you have a narrative that's big like social inclusion … it can get torn down so quickly. So the Social Inclusion Agenda is … at a high level, so you can go okay, there's your social inclusion narrative that means we want everyone to be able to participate in society and to be able to access things that other people can access … No one would disagree with the narrative, but then what's the policy solution? … At the level of policy [is where] you get all the arguments. [Participant 4]

As O'Flynn suggests, embedded ways of knowing and doing can restrain innovation when it comes to implementing new policy approaches (O'Flynn, Buick, Blackman, & Halligan, 2011). Hence, during implementation, those within government began to gravitate towards targeted approaches. The statements below indicate that policy-makers were more comfortable with targeted approaches and the intuitive logic of focusing on those most in need.

> I think there was some confusion initially in government about how hard they were focusing on it, what the breadth of the definition was. … There was a lot of discussion about [the balance] in the bureaucracy … Just what are we looking for? How do we approach this? How do we implement this Agenda? Do we do a big broad picture and try and attack everything or do we target? And in the end my understanding is that they decided to target. [Participant 2]

> We're looking for every Australian to participate economically, socially, every demographic, in the process and those sorts of things … In amongst all of that, what should the Social Inclusion Agenda focus on? … So the social inclusion vision is that all-encompassing thing, but the social inclusion … mission is about making a system more accessible for the most vulnerable people. [Participant 6]

Hence, while the 'vision' of the SIA was one of welfare state strengthening, in implementation it increasingly became focused on developing policies and programs targeted towards specific groups in need. Both the statement above and the quote that follows demonstrate a discursive shift towards targeted approaches and the logic underpinning it:

> When it was set up it was very much about the Australian community to be as inclusive as possible, and providing people with the opportunities to connect, everyone to connect with the community in a meaningful way … I mean that is obviously a very laudable aim to have, but the question becomes, well what does that mean in practice? … In terms of what a small group of people can do, it has to be focused on the most disadvantaged ….
>
> you do a little bit of work on everything and then you have no impact. … In practice, my observation is if it's not focused, it's kind of just useless …. [Participant 3]

Universal initiatives were thus seen as difficult to operationalise in practice, particularly within structures of government that emphasise demonstrable outcomes and policy impact.

Here, rather than building and extending universal services for the whole population, the SIA became about selective social services for the most poor. The agenda was seen as a way to, firstly, 'group together' policies that were focused solely on the very disadvantaged:

> In terms of saying let's gather up our policies and see if they meet these criteria for being part of the Social Inclusion Agenda, it's very good. [Participant 3]

And secondly, as a lens that encouraged government departments to shift investment away from the mainstream, towards the most disadvantaged 'bottom 5%':

> Service delivery reform under the Department of Human Services is quite a big aspect [of the SIA] which is seeing if we can shift all our services to focus on the bottom 5% [of the population]. [Participant 4]

This shift was rationalised as enabling the government to have more impact:

> I'm not saying that social inclusion doesn't apply to everybody, of course it does. But in terms of government intervention where does the government make its greatest impact? It makes its greatest impact by ensuring that people don't fall through the gaps. So it is about, I guess, the 5% at the bottom. [Participant 1]
>
> I think the reason, the rationale now for [what we are] doing is to actually give the social inclusion a sharp focus, where it has been too diffuse in its intentions and therefore been into everything, but influencing nothing. And in a pragmatic sense that's pretty ineffective. [Participant 5]

In this way, we can see that the imperative to give a 'sharp focus' to the SIA is underpinned by the entrenched view that universal approaches are difficult to realise in practice and are too broad to be linked with direct outcomes.

Discussion

The implementation experiences described by policy-makers indicate that policy-makers attempted to apply new universalist and inclusive values articulated by social inclusion to their practice. However, they were unsure of how to contribute to such a broad and expansive vision, arguing that universal approaches to social policy are ineffective and impossible to implement. They believed that as a policy 'about everyone' (both in the sense that the SIA was concerned with the whole population and that 'everyone' needed to be included in society), the SIA would become diluted and have little impact. This belief was used to justify a 'sharpening', or arguably 'narrowing', of the SIA to a focus on the most disadvantaged. In doing so, policy-makers were falling back on existing practices and understandings of policy design, which in Australia have favoured specific initiatives for at-risk individuals or groups. The difference between the original vision of the SIA and the way in which policy-makers responded to, interpreted and (in turn) implemented the agenda, speaks to entrenched ways of 'knowing and doing' with regard to the Australian welfare state.

While policy-makers called the SIA an agenda 'for everyone', rather than implementing an institutionalised approach to the welfare state, they began to fall back on existing knowledge, practices and experiences. In doing so, they became increasingly concerned with the delivery of targeted programs and policies for 'the bottom 5%'. In explaining this approach, they framed it as a 'fair' use of limited resources, i.e. a policy about helping everyone is 'very laudable' but in practice, government can have its greatest impact by focusing on targeted programs for the most disadvantaged.

As Weber (1922) suggests, social systems (such as governments) form their own system norms or 'systemic legitimacy'. Here, legitimacy is defined as the belief in the validity of order, whereby 'validity' is determined by the members of any given group (Weber, 1922). The 'practice norm' for policy-makers is to generate policy solutions that are sufficiently targeted towards 'problem populations' separated off from the rest of society, to appear to be doing something effective in practice (identifying and targeting a quantified, disadvantaged group separated from the rest of society through identified 'risk factors' and characteristics) while failing to challenge and address the underlying cause of disadvantage: the structural status quo of dominant interests, values and power relationships, which produce both 'winners' and 'losers' (Jamrozik, 1998). Seen in this context, it is therefore not surprising that policy-makers have found the SIA challenging. Universalist approaches are threatening to the political status quo because they force governments and society as a whole to accept responsibility for producing and maintaining disadvantage by pursuing dominant interests and values (Jamrozik, 1998). Indeed, welfare states are sociocultural institutions, with their own specific histories and cultures, which are difficult to displace, particularly in the relatively short time frame of a single policy or government (Esping-Anderson, 1990).

Universal social policies only come about when governments view them as expedient, meanwhile humanistic concerns can easily lead to residual social policy (i.e. compassionate relief of poverty or suffering) (Anttonen, 2012). Thus, although

policy-makers were cognisant of the need for a more 'institutional' (Titmuss, 1958) way of creating and implementing social policy, and agreed with the vision of the SIA, reconciling this understanding with their existing practice was problematic. In particular, when it came to the allocation of resources – be it money, programs or other forms of effort – their existing practice suggested they needed to focus on those most in need (i.e. in order to use resources fairly and to be effective). As McLaren and McIntyre (2013) argue, there is a 'powerful logic' to directing resources to those who need them most. It is worth noting that this slide into residualisation may also have been aided by the use of a guiding concept for policy, which is widely known for being open to interpretation from a range of ideological viewpoints and can be used to justify residual approaches (Carey et al., 2012).

When considered in relation to the growing evidence base on the links between strong and expansive welfare states and health, statements such as 'if it's not targeted it is not effective' are concerning. While the need to allow for the diversity of groups and individuals, and their respective needs, is increasingly acknowledged in both social policy and public health (Anttonen, 2012; Marmot, 2010), focusing on the most disadvantaged at the expense of attending to the 'whole', or other groups, will not support more equitable, healthy societies (Brennenstuhl et al., 2012).

Universal approaches, particularly within a neoliberal environment, may not always be perceived as practicable or cost-effective. These issues, along with 'scope' and the need for individual departments to demonstrate 'impact' are noted by policy-makers in this research as barriers to implementing a universal agenda like the SIA. However, residualisation is not the only alternative. Here, it may be useful to reflect upon a more complete range of social policy frameworks, beyond what is reflected in the responses of policy-makers to the SIA (Carey & Crammond, 2014b). In addition to universalism (i.e. where the whole population is treated the same) and residualisation (where assistance is only provided to the poor), is positive selectivism (where benefits are given to specific social groups, not determined by income) and particularism (emphasises distinctions in the way different people are treated, i.e. ensuring different groups *are* treated differently to accommodate, for example, sociocultural differences) (Thompson & Hoggett, 1996). Different combinations of these approaches may prove more palatable within a liberal welfare state context, while still bringing us closer to the goal of structural change. What the SIA has shown, however, is that these combinations may not 'fall out' of reform agendas naturally, in part because of the pull of residualisation. Herein lies a role for researchers.

Government's sense of its own capacity to enact broad-scale reforms has been identified as a barrier to more substantive, or 'transformative', policy change (Carey & Crammond, 2014a). Head (2013) notes that policy-makers are the ultimate generalists, which means that new knowledge is quickly inserted into existing schemas. To overcome this, a number of questions, or goals, should be kept at the forefront when working with policy-makers: 'Are we working on the most important problems?', 'Are we working at the appropriate scale (Micro, meso or macro?)', 'How do the micro, meso and macro interconnect?', 'How does this affect equity (as opposed to poverty)?' and 'What does this mean for action in terms of policy and practice?' (Head, 2013). Working alongside policy-makers to explore the types of questions identified by Head (2013), in addition to knowledge of available policy frameworks, is an important way to begin breaking down barriers to broad-scale reform.

Conclusion

Much debate about the benefits of universal approaches has centred around the state of the evidence in public health (Marmot, 2010). As McLaren and McIntyre (2013) have found, when it comes to arguing for universal action, not all questions can be solved empirically. This means that, to some degree, debates over targeted versus universal will always be values based – reflecting the nature of policy-making as a struggle over ideas (Carey & Crammond, 2014a; Titmuss, 1958). Arguably, this calls for a more dialogic approach than what is often set out in the evidence-based policy literature, which recognises that governments and their parts are sociocultural institutions with histories, norms and embedded practices that are not easily overcome through evidence alone. In recognising this, and understanding the nature of those practices, researchers will be better placed to suggest and work towards viable alternatives where universal policies and programs are unlikely to gain traction.

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