EDITORIAL

by Pete Alcock*

Social Innovation has in recent years increasingly been presented as an answer – perhaps even *the* answer – to the challenges facing welfare regimes at the beginning of the twenty-first century. All governments in advanced industrial nations with developed welfare states are finding it more and more difficult to secure the resources to meet the growing demands for welfare services, and to deliver these effectively to an ever wider range of welfare users. This is particularly true of the extensive, and at least in principle comprehensive, public services developed in the latter part of the twentieth century, where large public agencies have been established, employing large numbers of professionally trained workers and delivering services to all potential users of those services.

Perhaps the main example of these challenges can be found in the provision of health care and related social care. Nationalised provision of health and social care was one of the core welfare state reforms implemented in most welfare regimes in the last century. In the UK this was symbolised by the creation of the National Health Service (NHS) in 1948, which has since become a model for public health care internationally and a measure of British governments' commitment to public welfare provision. The NHS in the UK is now devolved to the separate administrations in Scotland, Wales and Northern Ireland; but in all it is the largest employer in the country, employing highly trained professionals, and providing training for thousands more every year. All governments have voiced their support for the principles behind the NHS; and, although it has been subject to a series of internal reforms in particular over the last two decades or so, evidence suggests that it continues to remain one of the most valued and supported public welfare services.

The importance, and the popularity, of the NHS in the UK meant that it has been spared from some of the most extensive public expenditure cutbacks implemented by government since 2010 to reduce the public deficit in the country. Nevertheless, funding for NHS has been reduced, and support for social care (largely provided by local government) has been cut even more. Yet at the same time health and social care services (as with welfare

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provision more generally) are faced with growing demands from changing user populations, in particular growing numbers of older people; and demands for access to an ever more sophisticated, and expensive, range of health and social care services.

From these traditional service providers therefore more is being demanded from less. Thus politicians and policy planners have become keen to explore any avenues for service change which may help to reconcile these competing pressures. Social innovation in service provision appears to provide an attractive opportunity here. If we can introduce innovation into the ways in which we design and deliver services, then perhaps we can do things differently, or even do different things, which would mean that more services could be provided to more people without simply expanding further existing service provision.

Social innovation has therefore become an increasingly important focus for policy debate and for policy research. This is taking place within welfare regimes and across international boundaries, notably within the European Union (EU), where the EU has supported a range of research programmes exploring the potential, and the practice, of social innovation in welfare services. This Special Issue provides a contribution to this research base by exploring some recent research on, and analysis of, the contribution of social innovation to the delivery of health and social care services in Italy and the UK.

Social innovation in welfare services can operate across a number of different dimensions, however. Innovation includes identifying and recognising the different kinds of users, and potential users, of welfare services, and the different needs that they may have. Traditional public services have sometimes been criticised for adopting a standardised – "one-size-fits-all" – approach to welfare users. Innovation can challenge this by demonstrating the importance of flexibility, and reflectiveness, in seeking out and responding to the different circumstances and needs of individual users. This may particularly be the case in health and social care, where individual circumstances and needs differ so much.

It is not just a more flexible approach to users that can be a source of innovation. We can also innovate in the ways in which we deliver services. This may involve changes in the way existing services are provided – doing things differently. It may also extend to providing new forms of support and service – doing different things. Innovation in how welfare services are provided has been at the heart of some of the recent debates about reform of health and social care services. This has included the *personalisation* of service provision – tailoring care services to meet the specific needs and

preferences of individual users. It has also extended to *coproduction* in service practices – where health and social care professionals work with users to include them directly in the design and delivery of services. Coproduction and personalisation have been embraced by policy makers and practitioners in the redesign of some health and social care services in the UK, and elsewhere, as some of the contributions to this Special Issue explore.

Much of the recent policy interest in social innovation has been focused not only upon what services are provided, however, it has also included changes in who it is who is providing them. Many of the welfare reforms of the twentieth century were based on the development of public services delivered by public agencies, primarily the different departments of central and local government. These public agencies were funded by public resources (taxation receipts) and accountable to elected public politicians, either nationally or locally. They were also generally large monopoly providers, which critics sometimes characterised as bureaucratic and inflexible – a common complaint about the NHS in the UK.

Despite this centralised, monopoly approach, however, state services have never entirely displaced the contributions of other providers of welfare services. Private market providers have continued to operate, and to flourish, in all advanced welfare regimes, including within health and social care, where private care now sometimes operates in tandem with public provision. Furthermore third sector organisations – charities, social enterprises, community groups and other voluntary agencies – have continued, and expanded, their roles as alternative, or supplementary, providers of welfare services. Again this is particularly the case in the fields of health and social care, especially following the UK reforms of the 1990s, which encouraged a wider role for third sector provision of social care to replace expensive public hospital provision.

In the last two decades or so, therefore, the role of private and third sector providers of welfare services has begun to grow more rapidly, driven by changes in the demand for, and supply of, welfare services in a changing economic and political context. Changes in *demand* are the result of the criticisms of centralised and bureaucratic state services and the recognition by governments of the desirability of promoting a more mixed economy of welfare through support for private and third sector providers as alternatives to state agencies. In the UK, and in many other advanced welfare regimes, this has increasingly taken the form of the commissioning of private and third sector providers to deliver services, which might previously have been provided by monopoly state agencies, most notably since the "community care" reforms of the 1990s. These alternative providers are still funded from

public (tax) resources, but receive these under contractual terms from the public commissioning agencies. Demand for alternative providers thus comes from public commissioners, and it has led to a growth in the number of large private companies delivering some public services in the UK; but also to a growth in the role of third sector agencies as alternative providers of welfare. Income from government contracts for service provision by charities in England and Wales has more than doubled over the last decade, with the largest area of provision being in health and social care.

The growth in the alternative provision of welfare services is also a product of change and expansion in the range of provider agencies willing and able to *supply* these services. This has included new private sector providers. But, as mentioned above, it has also involved an expansion of third sector organisations delivering public services under contract. This includes some large established charities; but it has also included many new and innovative providers. In places existing charities have been re-organised or restructured to provide new bases for delivering services – for instance, in the UK two leading providers of care services for older people merged to form a new and more flexible organisation, *AgeUK*. In addition entirely new providers have emerged, in particular through the moves by some former public service professionals to establish independent social enterprises to take over the public services that they formally provided. This is a trend which has been supported by recent governments in the UK through programmes of "mutualisation", which provide support for groups of health and social care professionals to create new organisations, based on principles of mutuality, and shift previously publicly provided services over to these.

What is particularly significant about these new alternative providers of public welfare services is that they hold out the promise of innovation in service design and delivery. The reason why the UK government is supporting the mutualisation of public services, especially in health and social care, is because of a belief that, when the professionals delivering these services are freed from the constraints imposed by the large bureaucracies found in state agencies, like the NHS, they will be able to move more swiftly and flexibly to innovate within their working practices and to improve their service outcomes. And this belief in the innovative capacity of third sector providers to introduce more flexible, more responsive, and perhaps also more efficient, welfare services extends to the other charities and voluntary organisations seeking to become alternative providers of welfare.

Social innovation in welfare services may include new ways of delivering services and responding to the needs of service users, therefore, and also the

role of new providers entering the public service field. Innovation is driven by demand from welfare users, especially where they are empowered by personalisation and coproduction, and by the supply of new ideas and practices from alternative providers. What is more these developments in social innovation are attractive to governments seeking to reconcile the increasing pressures of welfare demand and public expenditure constraint. In this context it is not surprising therefore that social innovation in welfare, and in particular in health and social care, has become an attractive aspiration for politicians and policy makers in the UK and Italy, and elsewhere.

However, despite the policy attention on social innovation, critics have sometimes argued that this may be little more than a rhetorical device to suggest that social innovation in service provision and the involvement of alternative providers can simply replace the service provision lost as a result of the retrenchment within traditional public services. Many policy makers, and even practitioners, may claim to be promoting social innovation; but there is relatively little empirical evidence of the extent of innovation in welfare services, or of the impact of this in improving or extending provision. There is also little evidence of the comparative advantage of third sector (or private) providers in service innovation. New providers may be operating in health and social care, for instance, but we do not know if they are acting more innovatively, or more effectively, than established public agencies.

It is the policy context of these moves towards social innovation, and the practical implications of this for the design and delivery of health and social care services, which informs the contributions to this special issue - focused in particular on the provision these services in the UK and Italy. They address some of the challenges we face in researching and analysing the extent to which such innovation is effective in addressing the problems facing welfare reform at the beginning of the twenty-first century.