Following the establishment of the modern system in the 1970s, personal social services in Britain once again experienced the turbulence of reform in the 1980s and 90s. The trend of the significant expansion of rights for social care dating from the end of the 1940s was reversed. The state no longer had the prime responsibility of service provision but became the enabler for other providers – private, voluntary sector and informal carer usually in family and neighbourhood – which were getting a much bigger role than ever before in caring. Moreover, this change coincided with the growing burden of individuals and their families for their own care. This was the clear direction of the reform had taken mainly by the 1990 National Health Service and the Community Care Act, under the Thatcher and Major Governments as shown in Chapter 5.

It is widely argued that this was inevitable because of the long-lasting economic constraint in Britain at that time (Ellison, 1998; Knapp, 1981). However the story does not seem to be so simple. Firstly, even though the personal social services had suffered from economic constraint since 1960s, and they were getting ever deeper after the oil crisis of 1973, it was not until the Thatcher Government that the fundamental structural change of social services became apparent. Secondly, it was true that social services drew more attention because of the sharp growth of the expenditure in the 1970s, but it started from on a very small level at the first (Webb & Wistow,
1986; T. White, 1981). Throughout 1970s, the proportion of personal social services in the total public spending had only increased from 0.9 per cent (1969/70) to 1.8 (1979/80) whereas, for example, spending on education had grown from 7.9 per cent to 10.8 in spite of the decrease in the school-age population (T. White, 1981). This means the marginal increase in social services spending was unlikely to be a notable burden on the government while it could still make big difference in the field (Barclay, 1982). Moreover, when the rise of social needs and the vulnerability of people under difficulty due to economic constraint are considered, the economic recession cannot automatically justify the reduction of the social service responsibility of the state.

This shows the explanation for the policy change in personal social services would not be sufficient only with the economic factors. This is one of the reasons the role of ideological factors in the policy development in 1980s and 90s being closely examined in this Chapter. This is conducted through the analysis of text in key policy documents – Green and White Papers – on personal social services under the Thatcher and Major Governments. This follows the extensive range of contemporary academic discussion in the area for comparison with the strategic thinking and choices of the government, like the previous chapter. Firstly, we look at the details of the key documents and move on to the discussion and the analysis in each analytical element including the contemporary challenges to social services, the policy objectives, the philosophy under the development, the role of major actors, the major strategies, and the concept of citizenship in social care reform.

The key policy documents of social services development

When it comes to the number of Green and White Papers, the Conservative Government in the 1980s and 90s seems to have had much less interest in personal social services. The Labour Government in the 1960s and 70s had one Green Paper and five White Papers including Better Services for the Mentally Handicapped (DHSS, 1971), which was published under Heath Government but the main work done by the Labour Government. By contrast, there had been just
three of them (one Green and two White Papers) in the area under successive Conservative Governments during a similar period.

The first one was the Green Paper *Care in the Community: a consultative document on moving resources for care in England* (DHSS, 1981a). It was the first ministerial document concerning the financial method for community care since it became one of the major issues in personal social services since the 1950s (Ramon, 1982). Policy guidance *Care in Action* quickly followed and most of the proposals were nationally implemented for the frail elderly, and people with learning difficulties and mental health problem to live in non-institutional settings (Cooper, 1989).

The Green Paper (DHSS, 1981a), as its title shows, narrowly concentrated on financial issues to move people in long-term care needs into a community setting, whereas the White Paper *Growing Older* (DHSS, 1981b), which was published in the same year, dealt with the comprehensive issues relating to the ageing population. This covered a much wider policy area, such as pension issues, but as it mainly addresses social care issues for the elderly, it is a good resource to see the initial understanding, position, and basic strategies of the Thatcher Government in the area.

However, the most significant document in personal social services in this period was, without any doubt, the White Paper *Caring for People: Community Care in the Next Decade and Beyond* (DHSS, 1989). This was one of the most significant policy documents in personal social service history in Britain and the first clear government statement of the goals and means of community care (Davies, 1994). The ground work was done by Griffiths who was asked ‘to review the way in which public funds are used to support community care policy and to advise me on the options for action that would improve the use of these funds as a contribution to more effective community care’ (Griffiths, 1988). The main proposal of his report, *Community Care: an Agenda for Action* (Griffiths, 1988) was reflected in the White Paper.

The analysis of the ideological influence in the policy development of personal social services is based on the text from these three Green and White Papers. Yet Griffiths Report (Griffiths, 1988) would be considered as a supplementary text where appropriate, similar to the Seebohm Report.
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The analysis follows the scrutiny of the contemporary discussion of academics based on literature in the next section.

The challenges to the contemporary personal social services

The growing social needs

The constant increase in social needs had been one of the most common concerns in the 1980s and 90s following the 1960s and 70s including aging population and other social changes such as shift of family structure and culture. If there are some differences from the previous period, some counter argument against the pessimistic demographic prediction is found in the literature of the 1980s. Many indicated the fast growing elderly population, particularly the ‘very elderly’ (80 or 85 and over) as they are usually regarded as relatively heavy users of social care (Challis & Davies, 1985; Davies, 1988; Finch & Groves, 1980; S. Green, Creese, & Kaufert, 1979; Knapp, 1981). However, Barclay (1982) pointed out there had been an offsetting decrease in the number of children, ‘the second main group of social service clients’ (Barclay, 1982 para. 6.7). Jefferys (1983) also argued there was socially a constructed panic over the aging issue whilst presenting evidence showing the majority of elderly had reasonable health so the increase in the number of very elderly would not be that significant.

However, in terms of other social factors, there had been more diverse concerns in the 80s and 90s than in the 60s and 70s over social changes causing more social needs by weakening the capacity of families for informal care (Barclay, 1982; Davies, 1988; Finch & Groves, 1980; S. Green et al., 1979; Knapp, 1981; A. Walker, 1981). The discussion of the shift of women’s status in society and labour market was one of them. They had been traditionally regarded as the core reserve army of carers. However, greater opportunities in the labour market together with the growing importance of women’s earning in the family due to economic constraints and unemployment, and the change in the conventional role division between genders by the influence of the campaign for sexual equality had been often indicated as a influential factors in creating this change in the status. Furthermore, there had been other factors damaging the caring...
role of family appearing in academic literatures in the 80s, such as increase in geographical mobility making considerable physical distances between the elderly and their children; smaller family size including a decrease in single daughter and an increase in lone parent family; the growth in divorce and remarriage weakening traditional family ties across generations. Medical progress and the higher survival rate of physically and mentally frail people was also one of them.

The lack of provision

While the growing need for personal social services was generally recognised by academics in the 1980s and 90s, there was also a general consensus that these needs exceeded the contemporary service provision (Barclay, 1982; Bilton, 1979; Mary Langan, 1990; Lelliott, Sims, & Wing, 1993; Madden, 1990; Pritchard & Cunliffe, 1983; Scrivens, 1979; A. Walker, 1981; Webb & Wistow, 1983, 1986; T. White, 1981). For example, Webb & Wistow (1983) pointed out that many local social service departments even failed to secure the 2 per cent minimal growth requirement for personal social services, which was stated by the previous government in the late 1970s. 27 per cent of them received less growth than the necessary amount to maintain the existing service level in 1978/79 and, in 1981/2, this number increased to 67 per cent. Barclay (1982 para. 7.21) illustrated this situation ‘… social workers [are] sometimes incapable of meeting authority’s statutory obligations …’.

There had been some particular concerns over the level of service provision in the community setting. After the closures of a number of institutions for people with learning difficulties and mental health problems, there was a growing worry about the shortfall of provision for the discharged people in the community (Madden, 1990). Some still indicate there was a significant number of people inappropriately placed in residential institutions including hospitals due to insufficient community services (Lelliott et al., 1993; T. White, 1981). This problem was not limited to services for learning or mental disability. A decrease in the level of other community services such as home help and day care centre against growing number of the elderly was also demonstrated (Mary Langan, 1990; A. Walker, 1981).

The collaboration between health and social services
The complex and divided service structure within the local authority, which was one of the most dominant issues of personal social services in the 1960s, had hardly been an issue in the 1980s since the establishment of a unified social service department. However, the problem of collaboration between health and social services drew more attention and this had been the most common criticism against the reform. The division of responsibilities between health and social services was considered not only unsolved (Cypher, 1979) but also ever deeper due to the reform (P. Hall, 1976; Wistow, 1982).

Even though they did not directly blame the Seebohm reform, many indicated this lack of collaboration between the two closely related services areas was recognised as one of the major challenges which should be addressed for further development (Dant & Gearing, 1990; Pritchard & Cunliffe, 1983; Webb & Wistow, 1986). This was considered a particularly important issue, not just for more integrated services for client but also for the community care policy, which was understood in many cases as the move from institutional hospital care to care in the community setting. The details will be discussed in the strategy section below.

The interpretation of the Government about the challenges

The recognition of the growing social needs particularly relating to the aging population was found in the Conservative government documents, not surprisingly, mainly from the White Paper, Growing Older (DHSS, 1981b p. iii para 1.1, 1.2, 1.7, and 8.2) and it understood the greater demands on social services. Other social factors damaging caring capacity within family such as change in family structure and greater geographical mobility were also identified. There are some examples:

We have had the needs of the growing numbers of elderly people – particularly the very old and frail – very much in mind in maintaining a high level of spending in the health and personal social services (DHSS, 1981b, p. iii).

Moreover, the cost of pensions represents only a part of the taxpayers’ and ratepayers’ money which public authorities devote to the care and support of elderly people. Special housing; health care in the community and in hospital; social services
and help in the home; and subsidies for fuel and travel are obvious examples (DHSS, 1981b para 1.7).

Variations in family structures and ways of living are emerging, altering the traditional family context in which older people live. An increasing number of families are the outcome of more than one marriage, and there may, in future, be more one-parent families. These changes, combined with the continuing mobility and consequent separation of younger and older generations, could reduce effective family support for many elderly people (DHSS, 1981b para. 9.4).

Most people needing community care are elderly and there is an increasing tendency for elderly people to live alone. … Growth will be greatest amongst the very elderly who are also most likely to be disabled and in greatest need of community care (DHSS, 1989 para. 8.10).

However, while they sometimes indicated there were many people with learning difficulties and elderly people staying unnecessarily in residential settings (DHSS, 1981a para 3.1 and 3.3), the shortfall of statutory service provision was barely admitted in the policy documents. This was rather understood as a problem of collaboration (DHSS, 1981a para. 4.3 and 5.4) or ineffective allocation of existing resources (DHSS, 1989 para. 1.6, 3.6.2, 8.5, and 8.15):

It has … been suggested that joint planning has been inhibited by the failure of staff of different authorities to understand the difficulties and different circumstances of their opposite numbers (DHSS, 1981a para. 4.3).

…. the arrangements for public funding have contained a built-in bias towards residential and nursing home care, rather than services for people at home (DHSS, 1989 para. 1.6).

… the provision of such services is uneven and poorly co-ordinated and there is tendency to match clients to services, rather than services to client needs (DHSS, 1989 para. 3.6.2).
... they [the arrangements for residential care from social security fund] have serious drawback. Their unintended consequences has been that priority has not been given to developing services to enable people to be supported in their own homes, with a consequent restriction on the choice available to individuals, their families and the professional care services (DHSS, 1989 para. 8.15)

**The objectives of social service policy**

If the discussions of the objectives in the 1960s and 70s was about the radical question on the role of personal social services within wider society, then those in the 1980s and 90s were more about the extent of statutory service ought to cover. This ideological divergence was well described in the Barclay Report (Barclay, 1982 para 7.3 - 7.7), which was one of the most comprehensive studies on their role in the 1980s – in fact, the role of social workers who are the main profession concerned.

Barclay presented two distinctive forms of objective depending on the ‘views about what ought to be the relationship between collective provision and individual forms of self-help; what ought to be the scope and policies of other services; and who ought to qualify to receive these services’ (Barclay, 1982 para. 7.3). One was the welfare state approach having the fundamental assumption that the state has an obligation to provide comprehensive services to respond to a wide range of social needs whatever they cause because all citizens have a right to these services. The other one was the safety-net approach saying state provision should be limited to the minimum and complementary to the informal caring network including families and neighbours which should be the primary source of care.

Bebbington & Davies (1983) also offered a similar classification of approaches with the concept ‘target efficiency’. It has two aspects with ‘vertical’ and ‘horizontal’. Higher horizontal efficiency referred to the higher service uptake rate by those in the target group and this was mainly stressed by the universalist as a necessary condition for social services to perform its function effectively. Vertical efficiency was more vital for selectivists as this is about the level of concentration of the resources on target group – i.e. the necessary condition for efficiency within
a narrower service goal. Compared to Barclay’s (1982) distinction, horizontal target efficiency relates more to the welfare state approach and the vertical one to the safety-net.

The positions of many commentators in the 80s and 90s (Challis, 1981; Dalley, 1996; Knapp, 1987; M. R. Olsen, 1986; Owen, 1986; Sainsbury, 1986; Webb & Wistow, 1987) were closer to the stands of the welfare state approach. Challis (1981) presented, in his study on criteria for the assessment, a comprehensive range of the objectives in social services such as fulfilment of basic needs of the client for comfort and security; compensation for disability; maintenance of independence; psychological well-being; reduction of isolation within community; a supplementary or complementary role for the family relationship; and the development of a social relationship for help and assistance. Webb & Wistow (1987) argued a more fundamental aspect of the objectives such as defence of the rights and well-being of (vulnerable) individuals; the promotion of the social environment, maintenance of a reasonably acceptable way of life; and equality of access to opportunity.

However, others were more sceptical about these kind of objectives. Pinker (1982) argued social services (or social work) has neither the capacity nor the mandate for these comprehensive goals for the community at large. This kind of perspective was also reflected in the Griffith Report saying public service can indentify an ‘actual and potential carer’ or ‘where … caring networks have broken down’, and these points were where public services were ‘desirable to fill the gap’ (Griffiths, 1988 para. 3.2 - 3.3). He limited statutory services to a supplementary role and dealt more with the ‘vertical efficiency’ of the services.

The emphasis on the independence of vulnerable people in the Government policy document sometimes seems to show a more comprehensive approach on the role of social services:

Strengthened primary and community care services will help elderly people to live independently in their own homes; services for those who are mentally ill, including in some cases residential, day care and other support, will enable them to keep in touch with their normal lives; and services for mentally handicapped people will enable them to live with their families, or failing that in a supportive local community setting (DHSS, 1981a para. 2.1).
The aim of the Government’s policies is to enable elderly people to live independent lives in their own homes wherever possible … (DHSS, 1981b para. 2.1)

Helping people to lead, as far as is possible, full and independent lives at the heart of the Government’s approach to community care (DHSS, 1989 Forward).

However, it is clear that this was not understood as a primary job for the statutory service, for example, ‘The increase needs of increasing number of older people simply cannot be met wholly – even predominantly – by public authorities or public finance’ (DHSS, 1981b para. 9.6). The Government’s objective statements were, therefore, more about vertical efficiency rather than the comprehensive fulfilment of social needs:

… the primary aim is a service in settings more appropriate to the needs of individuals being cared for (DHSS, 1981a para. 7.1).

The aim is to provide the care best suited to the needs of the individual, in the most effective and economical way possible (DHSS, 1981b para. 7.3).

We believe that the proposals in the White Paper provide a coherent framework to meet present and future challenges. … This offers the prospect of a better deal for people who need care and for those who provide care. Our aim is to promote choice as well as independence (DHSS, 1989 Forward).

The aim should be to ensure that all the available resources are put to best use, consumer choice and involvement are enhanced, and flexible services are provided which are tailored to individual need (DHSS, 1989 para. 3.5.4).

**Philosophy under the policy development**

The discussion on the fundamental perspective of social care was far more popular in the 1980s and 90s than any previous period as many considered the policies of the Thatcher Government as more of an ideological project (Biggs, 1994; Dalley, 1996; B. Hudson, 1990; Hunter, 1993;
Jordan & Jones, 1995; Lunt, Mannion, & Smith, 1996; Trnobrański, 1995; West, 1984). If we draw a line between the philosophical terrains in this period, in spite of a risk of oversimplification, it would be one between market individualism and collectivism. Yet the emerging empowerment discourse made this division more complex.

**Market individualism vs. collectivism**

Market individualism could refer to the wide range of perspectives having basically more interest in the heterogeneity of individuals, so more emphasis on individual responsibility, innovation through competition, greater choice. This may include consumerism and familism. Consumerism could also embrace various forms of approaches such as belief in neo-classical market principles, managerialism, and New Public Management (NPM).

Some coherent reasoning for consumerism can be drawn from various interpretations of the contemporary literature (Biggs, 1994; B. Hudson, 1990; Hunter, 1993; Jordan & Jones, 1995; Lunt et al., 1996; Marsland, 1996; McGrath & Grant, 1992; Trnobrański, 1995; Wistow & Barnes, 1993) as follows: ‘consumers can enjoy better quality of service more suitable for their individual flexible needs through the encouragement of greater competition between more diverse service providers’. Therefore, according to consumerism, state provision should be minimised not only for more space for private participation, but also for the disaggregation of public bureaucracies which can wield their monopoly power for their self-interest against consumers.

So Griffiths (1988) argued that ‘there is value in a multiplicity of provision, not least from the consumer’s point of view, because of the widening of choice, flexibility, innovation and the competition it should stimulate’ (Griffiths, 1988 para. 3.4) and the government ‘should encourage a proportionate increase in private and voluntary services, as distinct from directly provided public services’ (Griffiths, 1988 para. 4.6) Marsland (1996) also emphasised the majority of consumers should be encouraged to opt into an independent market.

However, there had also been a wide range of criticism of this consumerism approach. Many indicated that the actual choice was not practical for consumers due to various reasons such as the vulnerability of social service consumers, and the division between consumer and purchaser...
by the policy (Biehal, 1993; Hunter, 1993; Lewis, Bernstock, & Bovell, 1995; North, 1993; T. Smith, 1989). More fundamentally, Forder, Knapp, & Wistow (1996) demonstrated that the social care market was unlikely to avoid market failure theoretically because of its structural imperfections on account of the barriers to entry and exit such as higher rental or mortgage costs, property market boom and the falling number of volunteers as well as information imperfection on account of the elusive measurement and monitoring of service quality.

Others argued that more competition between a greater number of providers damages the much-needed cooperation and trust for effective service provision (Hunter, 1993; G. Wilson, 1994). Biggs (1994) was particularly concerned by the rise of ‘failed individualism’ which consider people being dependent on others for basic social survival as a being ‘failed individual’ as opposed to the praise for ‘succeeding individuals’, who enjoy their independence and choices.

In terms of social care, familism was regarded as another major form of market individualism (Dalley, 1996; West, 1984). Familism was interpreted as a perspective seeing the family as the best place for mutual caring and responsibility because of the natural kinship and understanding between its members (Dalley, 1996; Finch, 1984). This, rather, traditional form of familism was wedded to market individualism because the basic individual unit and its immediate family was regarded as the bedrock of capitalism for wealth, private property, and reproduction of labour force for market, and opposition against collectivist welfare provision which weaken Victorian values of family and individual responsibility. There were also other perspectives on social care issues which could be member of the market individualism family such as professionalism in social casework practice which focuses on individual matters rather than environmental or social factors (Webb & Wistow, 1987), and the medical model on disability limited its intervention to personal medical treatment and rehabilitation rather than other social issues (Ramon, 1982).

On the other hand, collectivism is basically associated with an egalitarian approach based on collective responsibility for social problems, having more interest in ordinary social needs rather than personal preference, and championing universal social provision being generally accessible according to needs (Dalley, 1996; Scrivens, 1979). The normalisation approach to social services (H. Smith & Brown, 1992) could be seen as a collectivist perspective considering its commitment to equal citizenship rights. It came from the understanding of the cause of disability...
which blames social stereotypes about disabled people rather than physical or mental impairment and aimed at every aspect of life of these people – living, working, and spending leisure time – in the same places and in the same fashion as non-disabled people. Other perspective focusing social and environmental factors such as the social model and structuralist approaches, for example, on mental health issues (Ramon, 1982; Tudor, 1991; Wistow, 1982), can be considered closer to collectivism.

*Empowerment and independence agenda*

The reason why a philosophical discussion of the 1980s and 90s should not end up with the plain dichotomy between market individualism and collectivism lies on the empowerment agenda emerged from both perspectives: the consumerist approach and democratising services (T. Smith, 1989). Firstly, in consumerism, there were elements developed from the consumer movement beyond simple market choice such as the emphasis on listening and responding to the individual (Madden, 1990; I. F. Shaw, 1984). Wistow & Barnes (1993) illustrate different types of consumerism, for instance, the development of consumer feedback; maximisation of opportunity, self-realization, and independence among disabled people; and user movement challenging the traditional ‘expert’ status of medical and social service professionals. These represent empowerment discourses in consumerism philosophy beyond choice in the social care market. They also indicated the consumerist reform of the Conservative Government showed a mixture of approaches to consumer involvement and choice (Wistow & Barnes, 1993).

However, not surprisingly, this is not an exclusive agenda for consumerism. Rather, collectivist traditionally had more initiatives against individualists in terms of empowerment issues such as citizen representation and participation. This approach appeared in the debate on the contemporary social care reforms. North (1993), for example, criticised that the Conservative government reform resulted in the empowerment of purchasers rather than service users and argued that the actual empowerment of users could not be achieved by consumerist reform but by the establishment of a participatory democracy within local social care services.

This collectivist participatory approach also links to the understanding of disabled and elderly people’s right just as an ordinary citizen and this includes an independence agenda (Beresford & Campbell, 1994). Independence for them was defined to have control over help with daily living
which means participation in society and personal relationships as citizens (Morris, 1994). In this approach, the concept of ‘care’ was challenged; the disabled and elderly people should not be just regarded as ‘dependent’ people who need to be ‘care for’. Instead, care should be understood as ‘care about’ someone who focused on bilateral or multilateral human relationships with the sense of loving rather than unilateral care provision.

In fact, the typical image of the caring relationship with a dependent elderly person and a young carer was often not true. Wilson (1994) showed an amount of carers were actually elderly people, those aged 60 to 75 from General Household data. Wilson (1993b) found clients and carers felt more supported by good personal relations with staff while practical help was said to make just a marginal difference in his interview, which meant ‘caring about’ was more valued than ‘caring for’ in practice. Caldock (1994) suggested, in addition, the term ‘services’ was suitable rather than ‘care’ since the former might refer to something to receive as their right within their control while the latter tended to be associated with dependent and passive recipients.

The philosophical ground of the government on social care policy

As many contemporary commentators indicated, the Government’s philosophy on social care based on market individualism is apparent in the text of White Papers. The consumerism approach is found in Caring for People (DHSS, 1989). It is clearly stated that they encourage more competition between more providers for better services and consumer interest:

The Government believes that people welcome this mixed provision of care, and that it encourages innovation, diversity, proper attention to quality and the interests of consumers (DHSS, 1989 para. 2.21).

Stimulating the development of non-statutory service providers will result in a range of benefits for the consumer, in particular:

- a wide range of choice of services;
- services which meet individual needs in a more flexible and innovative way;
- competition between providers, resulting in better value for money and a more cost-effective service.

(DHSS, 1989 para. 3.4.3)
The familism of the Government was also evident in Growing Older (DHSS, 1981b). Family is described as the ‘principal source of support and care’ and is ‘irreplaceable’ as the ‘best place’ for caring:

> These spring from the personal ties of kinship, friendship and neighbourhood. They are irreplaceable (DHSS, 1981b para. 1.9).

Most elderly people want to look after themselves, but when help is needed families are, as they have always been, the principal source of support and care. They are usually best placed to understand and meet the wide variety of personal needs which arise and their support is irreplaceable (DHSS, 1981b para. 6.7).

On the other hand, empowerment discourses, including not only consumer’s right to choose but also participation in decision making, are also found in both. However, the interesting point is that consumers’ choice and participation appeared in a limited sense. Choice can be exercised ‘subject to the availability of resources’ or ‘contribution towards the cost’. Even users’ representatives could not get exclusive status as citizens. They can be ‘consulted’ with an equivalent status to other private providers:

> … aged or frail, people living in residential accommodation are individuals with the same rights as everyone else to personal dignity, privacy and freedom to exercise choice. They are entitled to choose their own general practitioner and to receive the health care they need when they need it, including timely admission to hospital. They should be enabled to take part as much as possible in the day-to-day activities in the home; and relatives, friends and former neighbours should be encouraged to involve themselves in the life of the home (DHSS, 1981b).

The Government believes that, subject to the availability of resources, people should be able to exercise the maximum possible choice about the home they enter. The preference of relatives and other carers should also be taken carefully into account. If relatives or friends wish, and are able, to make a contribution towards the cost of care, an individual may decide to look for a place in a more expensive home. The
arrangements made by the social services authority should be sufficiently flexible to permit this (DHSS, 1989 para. 3.7.8.).

Authorities should also consult with, and take account of the views of, private and voluntary sector service providers, and representatives of services users and carers in drawing up their plans (DHSS, 1989 para. 5.7).

Furthermore, when it comes to the independence agenda, it is true that the Government repeatedly stated ‘independent lives’ as their objective as seen in the previous section. However, when we see their approach based on familism, their term ‘independence’ seems to be associated with independence from statutory service by informal care rather than independence for control over own daily lives as a right of a citizen with social support.

**Enabler, providers, and mixed economy of care**

*The changed of the role of state*

Even though it was true, in some extent, that a wider government role such as in the mobilisation of community resources and coordination between various organisations within community was considered, its prime duty and responsibility of social care provision was generally taken for granted during the 1960s and 70s as seen the previous Chapter. However in the 80s and 90s, this basic idea had been seriously challenged and changed. A state-monopolist approach was often accused of diminishing community moral, encouraging dependency, and expanding the phenomenon of the underclass (Marsland, 1996). although not all criticism of the monopolistic role reached this extreme, the bureaucratic features of state provision were often understood to be inevitably removed from flexibility and to become impersonal (Owen, 1986).

These concerns are associated with the greater emphasis on the active role and responsibility to encourage various sources of care provision i.e. mixed economy of care. For example, Barclay Report (1982 para. 3.40) argued ‘social services departments, through their social workers, have a responsibility for creating, stimulating and supporting networks in the community’. In fact, the Griffiths Report (1988 para. 5.2) confirmed ‘the major responsibility for community care rests
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best where it now lies: with local government’ and it suggested various roles of statutory authority including the assessment of individuals’ needs as well as the community needs; setting local priorities and objectives; designing a package of care and arranging the delivery; and, in the end, ‘the designers, organisers and purchasers of non-health care services. The former primary role as direct providers was abandoned and replaced by the role to maximise possible use of voluntary and private sector bodies to widen consumer choice, to stimulate innovation and to encourage efficiency’ (Griffiths, 1988 para 1.3.1 - 1.3.4).

The Government accepted this local government’s ‘enabling role’ but Griffiths’ suggestion was not the first. This idea had already appeared the White Paper in 1981, ‘The Government sees the primary role of the public services as an enabling one, helping people to care for themselves and their families by providing a framework of support’ (DHSS, 1981b para. 6.10). However, this role was more widely clarified in 1989 White Paper after Griffiths’ proposal:

The Government also endorses Sir Roy’s vision of authorities as arrangers and purchasers of care services rather than as monopolistic providers. In future, social services departments will have the following key responsibilities:

- carrying out an appropriate assessment of an individual’s need for social care (including residential and nursing home care), in collaboration as necessary with medical, nursing and other caring agencies, before deciding what services should be provide;
- designing packages of services tailored to meet the assessed needs of individuals and their carers. The appointment of a “case manager” may facilitate this;
- securing the delivery of services, not simply by acting as direct providers, but by developing their purchasing and contracting role to become “enabling authorities”;
- establishing procedures for receiving comment and complaints from services users;
- monitoring the quality and cost-effectiveness of services, with medical and nursing advice as appropriate;
• establishing arrangements for assessing the client’s ability to contribute to the full economic cost to the local authority of residential services.

(DHSS, 1989 para. 3.1.3)

Another important point worth paying attention to is that the responsibilities of the government were defined in the explicitly limited sense, ‘within available resources’ (DHSS, 1989 para. 3.3.1; Griffiths, 1988 para. 1.3). Moreover the statutory duty to arrange services was specified under the residual approach. In other words, publicly-funded social services were regarded as the last resort after it was confirmed that all other alternatives were not available:

Decisions [on care arrangement] will need to take account of the local availability and pattern of services as well as any sources of support available in the community – whether from family, friends, neighbours or local voluntary organisations … (DHSS, 1989 para. 3.3.1)

**Mixed economy of care**

The argument for the change of the government role in social care arose with the emphasis on the diversity of service providers and the competition between them. It was claimed that this mixed economy of care is to appreciate and encourage the present contribution and potential of the non-statutory sector; to prevent the dominance of providers’ interest and promote consumers’; and to develop a cost-effective provision of care (Bessell, 1981; Hadley, 1981). However, this by no means came without criticism. For example, while he appreciated the innovative feature of non-public providers and benefits to consumers of the contracting-out system by competition and choice, Knapp (1987) was sceptical about their long-term efficiency. He explained that non-public services looked more efficient because they had historically taken less difficult and dependent clients which would not be the case any longer as the change of trend by public sector placing more dependent people into them. Also he acknowledged the falling number of highly-motivated volunteers by the loss of independence and greater burden of provision.

Many critics went further and raised more fundamental questions about mixed economy of care (Biggs, 1991; Cooper, 1988; Deakin, 1996; Glennerster, Falkingham, & Evandrou, 1990; Mary Langan, 1990; Lewis, Bernstock, Bovell, & Wookey, 1996; Lunt et al., 1996). Glennerster,
Falkingham, & Evandrou (1990) summarised these criticisms well by the reference to the United States’ experiences in the social services market which showed time consuming and expensive contracts procedures; very few real competitors; another monopoly or oligopoly by large organisations; technical difficulties in measuring contract compliance; adverse selection bias toward less difficult cases; and damage on continuity of care by repeated bidding. Biggs (1991) argued that consumers lost their influence on care provision as the focus of ‘boundary transaction’ moved from the negotiations between provider and consumers to those between purchaser and providers through the mixed economy.

As seen in previous section about the consumerism of the Government, more innovation by competition and suitable services by consumer choice were what they expected through the mixed economy of welfare. So a number of commitments for the maximum use of private and voluntary providers in service provision and support for development of them are often found in the Government key policy documents (DHSS, 1981b p. iii para. 8.10 and 9.9; 1989 para. 1.11, 1.12, and 3.7.3). Moreover the Government’s money-saving perspective of these independent sectors is found in the following texts:

Money may be limited, but there is no lack of human resources. Nor is there any lack of goodwill. An immense contribution is already being made to the support and care of elderly people by families, friends and neighbours, and by a wide range of private, voluntary and religious organisations. We want to encourage these activities so as to develop the broadest possible (DHSS, 1981b p. iii).

Commercial organisations can help, particularly through fund-raising (DHSS, 1981b para. 1.10).

Private and voluntary organisations, including particularly religious, charitable and friendly organisations and trades unions, have a long tradition of providing residential care. … It is essential that their contribution should continue and expand. Some voluntary and private homes cater for a particular group of elderly people, for example former employees of a firm. There is scope for industrial companies and other large employers to consider whether, as part of their continuing responsibility
for employees after retirement, residential accommodation should be made available for those who may need it towards the end of their lives (DHSS, 1981b para. 7.10).

The Government will expect local authorities to make use wherever possible of services from voluntary, “not for profit” and private providers insofar as this represent a cost effective care choice (DHSS, 1989 para. 3.4.1).

*Voluntary and private sectors*

Voluntary sector involvement in social services with a complementary role had been generally welcomed as they were understood to have more innovative, participative, and flexible features in contrast to the heavily bureaucratised and professionalised public sector (Webb & Wistow, 1987). However, the approach of their involvement as a substitute to statutory care provision attracted huge criticism. Many of them argued that statutory responsibility was not replaceable by the voluntary sector as their relationship is not contradictory but complementary to each other (M. R. Olsen, 1986; T. White, 1981). They also pointed out that more dependence on the voluntary sector could result in an unbalanced provision of care since more volunteers and sponsorship was attracted in affluent areas than where greater need is placed (Cooper, 1988; Hatch, 1981; Mary Langan, 1990).

On the contrary, Knapp, Koutsogeorgopoulou, & Smith (1996) suggested that the socio-economic status of volunteering was not always positive and, rather, there was an inverse relationship based on their findings from a national survey on voluntary activity. In other words, they found more voluntary activity in lower income groups. Nevertheless it was only true with their wider definition of volunteering including informal care. As far as formal voluntary work was concerned, their evidence, instead, proved the adverse bias of voluntary care provision against greater needs.

Furthermore, there were the concern that voluntary sector would lose their unique features traditionally praised. It was indicated that the more voluntary organisations joined service provision, the more they use paid staff so the less significant cost-saving was expected (Cooper, 1988; Hatch, 1981). More importantly, voluntary organisations were worried about losing their independence as their increasing involvement in care provision under contract with statutory
authorities means they are more dependent on them financially (Cooper, 1988). This also influences other key roles of the voluntary sector such as campaigning and advocacy (Deakin, 1996). Lewis (1993) found in his survey many members in the organisation felt their activity was getting dominated by the provision of care.

As just seen above, the Government’s approach to mixed economy of care includes encouraging the development of the voluntary sector and maximum use of them in service provision. Particular appreciation of the valuable role of the voluntary sector and commitments for more support for them are often found in the text of in 1981 White Paper (DHSS, 1981b para. 6.13, 8.5, and 9.10). In 1989, statutory authority was asked to change its relationship with voluntary sector to a contractual one (DHSS, 1989 para. 3.4.13) but to keep grant type support for other roles such as advocacy, campaigning, and education (DHSS, 1989 para. 3.4.14).

However, as previously seen in the Government approach on mixed economy of care, the involvement of voluntary sector was not considered a supplementary role but a primary substitute to statutory provision. Moreover, as we can see in the following text, the Government perception of the voluntary sector was explicitly about additional or primary resources for caring or mobilising them, rather than an innovative and participative role. This makes sharp contrast with what we find in the understanding of the previous government about the voluntary sector which valued their high morals and unique contribution while being relatively cautious not to see them as an additional resource:

… it is easier to harness the energy and resources of the voluntary sector if people are in the community, rather than in hospital (DHSS, 1981a para. 3.7).

Whatever level of public expenditure proves practicable, and however it is distributed, the primary source of support and care for elderly people are informal and voluntary (DHSS, 1981b para. 1.9).

Much can be done by voluntary organisations, working alone or in partnership with the public authorities… (DHSS, 1981b para. 6.9)
Voluntary organisations can make a vitally important contribution, particularly in helping to mobilise informal help on discharge … (DHSS, 1981b para. 8.5)

The other non-public provider, the private sector attracted far less attention from academic literature but more severe criticism on their role in service provision. While their massive extension throughout the 1980s was recognised (Challis & Hugman, 1993; B. Hudson, 1990) they are widely condemned for their biased interest in affluent clients and cream skimming against difficult and expensive ones – service provision not based on needs but affordability (Cooper, 1988; Deakin, 1996; Jefferys, 1983). However, on the contrary, a different perspective of the private sector in social service provision was found in the Griffiths Report: ‘The best examples show how services can respond very flexibly to meet the particular needs of individuals in a way that is acceptable to them and takes full account of their personal circumstance’ (Griffiths, 1988 para. 4.5). This perspective seems to be reflected in the Government approach for the expansion of private provision in social care seen above.

**Strategies in personal social service policy**

*Community care as a core agenda*

As far as personal social services are concerned, ‘community care’ was at the centre of policy development as well as academic debate throughout the 1980s and 90s. It is interesting because there had been a kind of ‘consensus’ about community care in the previous period as the right direction for social care policy since it emerged in the 1950s. At that time, community care was generally understood as a shift of place of care from a Poor Law style large institution to a homely setting or home within the community i.e. care *in* the community.

However, while this kind of community care still mattered, the discussion around ‘community care’ was getting more complex forms. The first one could be the move of care responsibility from the state to ‘community’ – family, relatives, and neighbours – i.e. care *by* the community. Yet, in fact, the actual policy proposals for community care were appeared more about a decentralisation agenda. This includes a range of government funded community care projects
conducted in various regions in the 1980s. As each kind of community care had different issues as a policy agenda, it would be appropriate to discuss them one by one.

Care in the community

Even if there were no longer any Poor Law type, inhuman, large institutions, it was still important issue to replace inappropriately hospitalised or institutionalised vulnerable people such as people with learning difficulties and elderly people back into their own community not very different from those in the 1960s and 70s (Bessell, 1981; Davies, 1981; Lelliott et al., 1993; Madden, 1990; Ramon, 1982; T. White, 1981). Yet there was also a striking difference in the discussion. That was the arising criticism in the 1980s and 90s against some policies for care in the community, which had a near consensus status in previous period.

The first target of the criticism was the impetuous closure of institutions without proper development of community support under the name of ‘community care’ (Chapman, Goodwin, & Hennelly, 1991; Knapp, 1987; Mary Langan, 1990; Scull, 1986; Webb & Wistow, 1987). Community care was, the point of view of the central government, the shift of more care provision from expensive NHS facilities to local authority institutions and, from the local authority perspective, the pressure to substitute cheaper care options such as day care and domiciliary care for the expensive local institutional care (Webb & Wistow, 1983). Knapp (1987) pointed out this de-institutionalisation moved forward faster than anyone had expected and there was not enough time for the development of a community care service to adapt and respond it.

There were also questions about the claim that community care is a cheaper substitute (Knapp, 1987; O'Shea & Blackwell, 1993; I. Philp et al., 1995). Knapp (1987) indicated that there were the ‘hidden’ costs, such as housing grants, social security and day care costs for community care and O'Shea & Blackwell (1993) added their argument about more costs for informal care. This will be discussed further below.

Some critics went further. They were sceptical about community care itself. Goodwin (1989) raised questions about the origin of community care policy. He argued that common knowledge about the development in mental health on account of a new drug treatment was exaggerated as there was, in fact, no significant curative effect. He claimed that institutional care for mental
health was deserted not because of modern enlightened thinking but because of the failure to increase its capacity to match rising demand. In addition, Chapman, Goodwin, & Hennelly (1991) pointed out the ignorance of the client views about community care and quality of service. Higgins (1989) argued, moreover, that ‘community care’ is an unhelpful concept because of its ambiguity as it could mean care at home, daily care in another place, or even institutional care within community.

However, there was a renewal of the demand for care in the community. Morris (1992) claimed that disabled and elderly people could have a better quality of life within the community almost without exception while disapproving of other feminist criticism on community care which will be addressed below. Dalley (1996) made an interesting suggestion for collectivist alternative form of community care satisfying a number of collective care principles – responsibility for own life choices, responsiveness to needs and preferences, opportunity for a wide range of personal relationships, integration and normalization, and economical security. This was the group living model with people having various levels of dependency, sharing not only care and support but also communal life while supported by a living-alongside or regular-coming carer.

Care by community

Community care had not only been a matter of place where people were cared for since the 1980s. In community care, sometimes called community social work or community-centred approach, maximising the capacity of the community to provide care was regarded as an alternative to meeting growing social demands on caring (Barclay, 1982; Hadley, 1981). Moreover, ‘care by community’ was sometimes understood to be a more effective and sensitively humane way of care than care by ‘professional’ (Butcher, 1986).

Barclay (1982), in particular, claimed in his well-known report on the role and tasks of social workers that ‘if social needs of citizens are to be met in the last years of the twentieth century, the personal social services must develop a close working partnership with citizens focusing more closely on the community and its strengths’ (para. 13.1) and members of the public should be regarded ‘as partners in the provision of social care’ (para. 13.2). In this respect, community was defined ‘as a network, or networks, of informal relationships between people connected with each other by kinship, common interests, geographical proximity, friendship, occupation, or the..."
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giving and receiving of services – or various combinations of these’ (Barclay, 1982 para. 13.6) and ‘An important feature of community is the capacity of the networks of people within it to mobilise individual and collective responses to adversity’ (para. 13.7).

Severe criticism of this claim mainly came from the question of the meaning of ‘the community’ in practice (Finch, 1984; Finch & Groves, 1980; S. Green et al., 1979; J. Higgins, 1989; Jefferys, 1983). These critics pointed out, when it comes to care by the community, it was not the ‘community’ who provide care but identifiable groups and individuals: women. They recognised, in reality, the majority of the caring burden already fell on women’s unpaid or low-paid labour and so claimed that further pursuit of community care was nothing more than additional sacrifices from women. Finch (1984) concluded ‘no non-sexist version of community care seems possible’ (p. 12).

The proposals and projects for community care

The actual community care which appeared in proposals and government pilot projects in the 1980s was more complex form than just ‘who cares where’ issue As an alternative form of care replacing large, slow, and unresponsive bureaucratic and institutional care, generally two different decentralised forms of community care models were presented at that time. The first one was the localised geographical patch team system which was the allocation of social work staff to a limited geographical area (Barclay, 1982; Hadley, 1981). The more active participation of informal and voluntary community network and effective response to unique local needs were expected in this model.

However, the model which was adapted into regional pilots and well documented in empirical studies was the other one – the so called ‘Kent Community Care model’ (Challis, Chessum, Chesterman, Luckett, & Woods, 1987; Challis & Davies, 1985; Chesterman, Challis, & Davies, 1987). This was the decentralisation of resources rather than geographical area. Accordingly, this model included the following points: devolution of control of resources to individual field workers; defined caseload and expenditure limits to ensure accountability; and the provision of more flexible, responsive, and coherent individual packages of care. If the patch team model was a more generalist approach, this Kent model was a more specialist one focusing on special client
groups with complex needs and adapting a specialist case management concept which will be discussed below (Goldberg, 1987).

The empirical studies to evaluate a range of community care schemes in various regions such as Kent and Gateshead, found a number of advantages of this model although there was some variation between the regions (Challis et al., 1987; Challis & Davies, 1985; Chesterman et al., 1987; Rushton, 1990). They were longer survival rates, lower admission rates to hospitals or institutions, higher satisfaction and quality of care, and less stress and disturbance of care. However, in terms of cost, there was a mixed picture or no significant differences. For example, in the Kent Scheme, the model cost less for local authority but more for the NHS while there was no significant difference in Gateshead comparing to standard service provision. When other benefits were considered, this model was generally accepted as, at least, a cost-effective alternative. Yet many highlighted that this would be by no means cheap option (Butcher, 1986; Dant & Gearing, 1990; Glennerster et al., 1990; Lewis et al., 1995). They argued that, in order to achieve the benefit of the model, it required substantial investment.

Community care of the Government

First of all, community care was the central concept of the Government reform on personal social services, as seen in the title of the Green and White Papers: ‘Care in the Community’ (DHSS, 1981a) and ‘Caring for people: Community Care in the Next Decade and Beyond’ (DHSS, 1989). Yet what matters is, as just seen in the contemporary discussion, which kind of community care it was. It was found in the text that community care for the Government was particularly ‘care in the community’:

Most people who need long-term care can and should be looked after in the community. This is what most of them want for themselves and what those responsible for their care believe to be best (DHSS, 1981a para. 1.1).

Community care services play a vital role in enabling elderly people to remain in their own homes and in preventing or deferring the need for long term care in a residential home or hospital (DHSS, 1981b para. 7.2).
Community care means providing the services and support which people who are affected by problems of ageing, mental illness, mental handicap or physical or sensory disability need to be able to live as independently as possible in their own homes, or in “homely” settings in the community (DHSS, 1989).

The actual policy strategy for care in the community was no more than a further development of various services available in the community such as domiciliary care, day care services, respite services, and sheltered housing. Other decentralised forms of community care, such as the geographical patch team system, the devolution of resource to field level, limited caseloads, were not included the Government’s form of the community care. Although there are some word like ‘flexible’ services or delivery, the resources control was no further devolved than the local level and there was no mention about the reorganisation of social services departments. Moreover, a specific grant to develop community care, suggested by Griffith Report was also rejected:

to promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible (DHSS, 1989 para. 1.11).

Community care means providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives. For this aim to become a reality, the development of a wide range of services provided in a variety of settings is essential. These services form part of a spectrum of care ranging from domiciliary support provided to people in their own homes, strengthened by the availability of respite care and day care for those with more intensive care needs, through sheltered housing, group homes and hostels where increasing levels of care are available, to residential care and nursing homes and long-stay hospital care for those for whom other forms of care are no longer enough (DHSS, 1989 para. 2.2).

There is great scope for establishing clear policy frameworks and guidance for resource use, and for increasing the provision of more flexible and intensive personal care services for people who would otherwise require institutional care (DHSS, 1989 para. 3.6.2).
The Government believes that the range and diversity of domiciliary care services can be greatly increased by enabling those responsible for planning, managing and delivering the services to operate flexibly. Delegation of responsibilities for recourse management to local level, and the encouragement of tendering for certain services are means of stimulating the growth of new domiciliary and day care services in the independent sector (DHSS, 1989 para. 3.6.3).

The Government gave careful consideration to Sir Roy Griffiths’ case for a specific grant but concluded that a large scale specific grant is not necessary to secure community care objectives (DHSS, 1989 para. 8.25).

Some criticism of care in the community was appreciated by the Government. For example, it was stated that ‘Ministers will not approve the closure of any mental hospital unless it can be demonstrated that adequate alternatives have been developed’ (DHSS, 1989 para. 7.5) in order to prevent the victimisation of patients with mental health problems by community care policy. However, the intention of the Government for care by the community is ever clear. This was the move of care responsibility from a statutory service to the community: ‘Care in the community must increasingly mean care by the community’ (DHSS, 1981b para. 1.9) and ‘in many cases it would both be lower and better value’ (DHSS, 1981a para. 3.7). We can also find the concept of ‘community’ being used as something not in the public sector in the following text:

Much can be done within the community, independently of public authorities, to organise help with the many minor everyday tasks which can present difficulties for elderly people (DHSS, 1981b).

Providing adequate support and care for elderly people in all their varying personal circumstances is a matter which concerns – and should involve – the whole community: not just politicians and officials, or charitable bodies (DHSS, 1981b para. 1.11).

Nor should community care be seen as the prerogative of public services (DHSS, 1989 para. 2.21).
Case management

Case management is a social work method, originally developed in the United States and Canada in response to service fragmentation, poor resource targeting, a lack of collaboration between various services and the difficulty of coordination between statutory and informal care (Biggs, 1991; Dant & Gearing, 1990; Levick, 1992). This was introduced in Britain mainly through a range of Government funded community care projects, including some discussed above (Challis, Chesterman, Traske, & Richard, 1989; Davies, 1988; Levick, 1992).

Like community care, case management in the 1980s and 90s had various different approaches but there were also common features between them. Most of the approaches included the following points: a care manager who is responsible for needs assessment, planning a package of care, and constant monitoring and evaluation for a certain case or client (Dant & Gearing, 1990; Davies, 1988; Huxley, 1993). A number of commentators presented a range of conditions for successful case management based on empirical evidence from community care projects in Britain (Cambridge, 1992; Challis et al., 1989; Levick, 1992; Wistow & Barnes, 1993) or experiences from the United States and Canada (Dant & Gearing, 1990). While a range of community care projects in Britain proved a number of advantages such as longer survival, better quality of life, and less admission to institutional care as was seen above (Challis et al., 1989), the most common conditions for this successful result included the devolution of resource control to care manager level including funding as well as service supply. Cambridge (1992), in addition, introduced further conditions such as comprehensive and multidisciplinary assessment; facilitating user involvement; a mixed economy of care; and the independency of the care manager.

Challis, Chesterman, Traske, & Richard (1989), in particular, demonstrated two different case management models. One was the ‘complete model’, which was adapted by the community care projects, including not just an administrative function but also the wider roles of care manager including assessment, counselling, and supporting and advising carers. The other model was the ‘administrative model’ which incorporated the administrative roles – service arrangement and coordination – into the central tasks of care manager. The latter was, they said, more likely to be
adapted into common practice but it would be a more expensive form of service delivery without further benefit.

There were some expectations about the introduction of case management, as a client-centred approach, to reveal existing unmet needs and provide more accessible and acceptable levels of services, and, at the end, to empower the wider public (Levick, 1992). However they did not come without criticism. For example, Wilson (1993a) concluded in his study that case management was exceedingly time consuming and a source of stress. He added that care managers were trapped between incompatible roles: producing satisfactory packages of care within a rationed service provision. Moreover, Caldock (1994) pointed out that there was a fundamental contradiction within case management between the emphasis on user choice and participation, and the stress on cost-effectiveness.

Furthermore, Biggs (1991) raised a question about the method from its origin, arguing case management was developed from the unique circumstances of the United States where caring was inadequately and partially funded by insurance companies, which was not the case in Britain. On the other hand, Osborne (1991) was critical about not adapting the case management model from the other country, Canada, in which budgets devolved into consumers, case managers were employed by consumers and so was a far more empowering model for service users.

The Government, in their White Paper, explicitly mentioned the introduction of case management into social services:

People’s care needs may change over time and therefore need to be monitored. Where an individual’s needs are complex or significant levels of resources are involved, the Government sees considerable merit in nominating a “case manager” to take responsibility for ensuring that individuals’ needs are regularly reviewed, resources are managed effectively and that each service user has a single point of contact. The “case manager” will often be employed by the social services authority, but this need not always be so (DHSS, 1989 para. 3.3.2).

Case management provides an effective method of targeting resources and planning services to meet specific needs of individual clients. The approach has been
successfully employed in a number of schemes and projects, some of the best known of which are in Kent, Gateshead and Durham (DHSS, 1989 para. 3.3.3).

Even though the community care projects are mentioned as above, the model the Government actually adapted was far from what the evaluators (Challis et al., 1989) expected. The role indicated for case management was limited to the ‘administrative model’ excluding wider tasks for care managers such as counselling and advising for a ‘complete model’. Even administrative tasks could be divided into different managers in each stage:

To be effective case management should include:

- identification of people in need, including systems for referral
- assessment of care needs
- planning and securing the delivery of care
- monitoring the quality of care provided
- review of client needs.

It is not essential that the same manager should undertake all these tasks for a particular client but a clearly identified individual should be designated for each function (DHSS, 1989 para. 3.3.4).

The conditions for successful case management commonly indicated in the contemporary literature, such as the devolution of resource control to care managers, was appreciated by the Government although it would not be applied to every case. However, the point was at the effective use of existing resources rather than the sufficient use to meet clients identified needs, which was the main point of the literature. This reminds us of Wilson’s (1993a) findings showing the stressful position of the care manager between user’s need and rationed resources:

The Government also sees advantage in linking case management with delegated responsibility for budgetary management. This need not be pursued down to the level of each individual client in all cases, but – used flexibly – is an important way of enabling those closest to the identification of client needs to make the best possible use of the resources available (DHSS, 1989 para. 3.3.5).
Planning

Planning in personal social service was generally understood as the process of indentifying existing demand and available resources and then determining what needs should be met and how (Webb & Wistow, 1986). This process was regarded as being particularly important when there was scarcity of resources and universally considered explicit criteria for service was the crucial point (Scrivens, 1979). Barclay (1982) claimed that planning was one of the core roles of social workers along with counselling to fulfil their responsibilities.

Since the local planning was introduced as one of the measures in the Government reform, there had been some expectation that this would lead to user empowerment. Levick (1992) argued that any unmet or inadequately met needs and local social service policy to tackle them would be revealed publicly through this planning. Hence he expected this would trigger a wider local debate about service provision issues. Hudson (1992) also indicated that there was an opportunity for users and carers to become involved in the planning and service delivery process and this could encourage focusing on practical outcomes to improve the quality of their lives beyond that of the services.

In the Government White Paper, as discussed, planning was stated as one of the new measures:

… local authorities will be expected to produce and publish clear plans for the development of community care services, consistent with the plans of health authorities and other interested agencies. The Government will take new powers to ensure that plans are open to inspection, and to call for reports from social services authorities … (DHSS, 1989 para. 1.12)

However, its context looks rather different to what had been expected in the literature. The focus of the planning was neither revealing unmet needs nor consultation with users and carers. It appeared to be a method to ensure that national policy and priority is implemented by the local authority, such as the increase in use of the non-statutory sector and non-residential care, and that the role of local authority shift to being an enabler. In short, planning was accepted as an effective central control tool over local authorities:
Social services authorities will be expected to make clear in their community care plans what steps they will be taking to make increased use of non-statutory service providers or, where such providers are not currently available, how they propose to stimulate such activity. In particular, they should consider how they will encourage diversification into the non-residential care sector (DHSS, 1989 para. 3.4.5).

The Government will bring proposals before Parliament to:

- require local authorities to draw up and publish plans for community care services, in consultation with health authorities and other interested agencies;
- enable the Secretary of State for Health to call for reports and information from local authorities where he has reason to think these may be needed, and to specify the form in which they are to be provided;
- enable the Secretary of State for Health to issue directions and give guidance over the full range of personal social services activities by local authorities.

(DHSS, 1989 para. 5.3)

Local authorities will need to have clear plans for the development of their community care provision against which their performance can be monitored and assessed. The purpose of such plans will be to enable social services authorities to:

- set out strategic objectives and priorities and, over realistic planning periods, set specific targets, in collaboration with relevant agencies;
- take account of the needs of people who have been in hospital a long time, and need help to re-establish themselves away from large institutional settings;
- assess other local needs, taking account of the results of assessments in individual cases;
- organise their move away from the role of exclusive service provider to that of service arranger and procurer;
- ensure that service arrangements respect and preserve individual independence, include adequate quality control systems, offer freedom of choice, and provide services in a sensitive and responsive way;
- monitor performance; and inform the public.
Collaboration between health and social services

As discussed in the Challenge section, poor collaboration between health and social services had been widely recognised particularly since the establishment of the social services department. And it became a more important issue as the move of inappropriately hospitalised people into a community setting became one of the major government policies on community care. The Green Paper *Care in the Community* (DHSS, 1981a) was published mainly for this issue. Hence, various suggestions for this purpose were suggested in the Paper such as joint finance, a lump sum payment from health to local authority, the transfer of hospital buildings, the pooling of funds for a client group, the central transfer of funds, establishing a NHS fund, and placing responsibility for a client group into single authority (DHSS, 1981a para. 6.3 - 6.27). Other proposals were presented in the White Paper, *Growing Older* (DHSS, 1981b) such as liaison officer between the two authorities.

However, many criticised the government approach (Benington, 2000; R. Higgins, Oldman, & Hunter, 1994; Nocon, 1989; Webb & Wistow, 1986). Webb & Wistow (1986) claimed that joint finance could not be successful without a sufficient and consistent increase of funding in the social service department because there was a fundamental concern about the end of the joint finance programme which meant the more significant cut, the more local authorities had to compensate. Nocon (1989), moreover, found systematic ignorance in the joint planning between health and local authorities and from each of them. R. Higgins, Oldman, & Hunter (1994) draw some lessons from their study on a local community care project, namely that more inter-agency training and education, clearer objectives and joint management, and more explicit resource availability were required for successful collaboration.

However, no significant measure appeared in the 1989 White Paper (DHSS, 1989) for the improvement of collaboration. Rather, joint planning was replaced by a planning agreement between the two authorities so aims, funding, and further collaboration were left to their discretion(DHSS, 1989 para. 4.25 and 6.10).
Citizen, another provider and consumer

Responsibility as informal carers

The ultimate protection of citizen rights being the principal responsibility of the state was generally taken for granted not only in the academic literature but also in the text of the Government documents in the 1960s and 70s, as discussed in the previous Chapter. The principal duty to care for citizens was considered to fall on the state. However, in the 80s and 90s, this was challenged profoundly and the primary duty of care appeared to move to the citizen, particularly, in the name of ‘community care’ (Phillipson, 1994), as seen in the discussion on ‘care by community’. Barclay (1982 para. 13.14) claimed that ‘The citizen has more often been encouraged to think of his rights as an individual than of his responsibilities as a member of a community’. Madden (1990) insisted that the dependency culture of the welfare state could be prevented by emphasizing the duties of the family and the community. Yet this was not only a responsibility issue but also a matter of money and resources. The community care approach which meant the active use of informal resources with formal ones was argued, although not cheap, to ‘make sense’ (Barclay, 1982 para. 13.22) and ‘good value for money’ (Barclay, 1982 para. 13.68) particularly under circumstances such as increasing demand with constrained resources.

However, this recognition of citizens as informal care providers was not all about the request for primary responsibility for caring. It was also the appreciation of the reality that the majority of the care burden had been already shouldered by informal carers (S. Green et al., 1979). As the substantial proportion of them were found to be suffering from significant stress and difficulties (Goldberg, 1987), many commentators emphasised public support for carers. Yet there were different extents and points of the arguments. While the greater support for informal carers was often justified in order to maintain or encourage their caring capacity rather than to lift the burden (Barclay, 1982; Goldberg, 1987; S. Green et al., 1979; Griffiths, 1988; Owen, 1986; A. Walker, 1981; Webb & Wistow, 1983, 1986), others raised the fundamental question about this principle responsibility claim.
The latter was based on another reality about caring. While the majority of the care burden was placed on the family and the community, again, the majority of them fell on a particular group of people: women (Bebbington & Davies, 1983; S. Green et al., 1979). It was argued that informal caring in the community was accepted and encouraged at the expense of the basic rights and opportunities of women to work, or even, to marry, as the significant and constant burden of caring was falling on them from children to the elderly throughout their lifetime (Finch & Groves, 1980; J. Walker, 1988).

Rights as consumers

The severe challenges to the rights of citizens and the emphasis on duty were not the whole discussion on citizenship in social care during the 1980s and 90s. Another type of right was encouraged and praised in the name of ‘consumer choice’. In other words, as a part of consumerist approach, consumers were believed to enjoy their right to choose better and more suitable care services for their individual needs from various providers who could be more innovative and flexible under competition than the self-interested and monopolistic bureaucracy. However, much the same as the discussion over consumerism, this argument attracted extensive criticism.

For instance, North (1993) claimed the consumerist approach diminished the right of citizenship on its own account by defining service users as greedy consumers and considering access to services as a privilege rather than a right. However, more critics aimed at the reality of social care market in which consumerist principles were unlikely to work. Biggs (1991) and Means & Langan (1996) pointed out that, in fact, there were few real choices for care service consumers. For the very elderly or people with disabilities, when the service was usually given at a point of crisis, going elsewhere was not considered a realistic choice, despite any dissatisfaction they may feel.

Further criticisms brought attention to the actual proposal of the Government for a social care market which let the local authorities buy the services for the users rather than allowed the consumers to do so for themselves. They disapproved of this proposal because those who had the choice, control, and negotiation over services were the purchasers (the statutory authority). Therefore, the consumer was even considered more excluded and disempowered than in the
previous system (Biggs, 1991; Cornwell, 1996; Knapp et al., 1996; Levick, 1992). Wilson (1994) pointed out that the practical situation of care managers namely that they could not solely respect consumers choices due to the demands for strict rationing with a fair distribution between rising demand and constrained resource.

On the other hand, as seen in the empowerment agenda in the philosophy section, the consumerist approach was not only about choice ‘at the point of sale’ in the market. If this is not a real option for consumers, the importance of the ‘voice’ of the consumer through assessment, planning, and complaint procedure would be more considerable in social care (Lewis et al., 1995). Hence, there were a number of pieces of literature presenting methods and matters for effective and substantial user participation (M. Barnes & Wistow, 1994; Bewley & Glendinning, 1994; Biehal, 1993; Bowl, 1996; Hartley Dean, 1993). The most common lesson which could be drawn from these studies was that what really matters in terms of user involvement is information and power. They concluded that, based on their findings from some pilot projects, the empowerment of consumers could be no more than rhetoric unless clear information was given to users about available services; eligibility for them; the quality and performance of them; and having the substantial power of decision-making on planning and management transferred to user representation equivalent to that of professionals.

The conception of citizenship in the government

The reality of social care, the majority of the burden falling on informal carers’ shoulders, was largely appreciated by the Government and their commitments to help and support are found in the text. However, as seen in the philosophy section above, their approaches were based on the idea assuming the primary caring responsibility of the family and community. Accordingly, this reality is described as the desirable – ‘always will be’ (DHSS, 1989 Forward) – and morally right thing to maintain – ‘it is right that they should be able to play their part’ (DHSS, 1989 para. 1.9) – rather than change it. This leads to the limited extent and purpose of their commitment for support to carers no more than ‘to continue to carry out their [caring] role’ (DHSS, 1989 para. 1.9) and ‘to maintain their valuable contribution’ (DHSS, 1989 para. 2.3). While this is even regarded as ‘right and a sound investment’ (DHSS, 1989 para. 2.3), there is no mention about the lost rights and opportunities of carers, for example, in employment:
The greater part of care has been, is and always will be provided by families and friends (DHSS, 1989 Forward).

The Government acknowledges that the great bulk of community care is provided by friends, family and neighbours. … However, many people make that choice and it is right that they should be able to play their part in looking after those close to them. But it must be recognised that carers need help and support if they are to continue to carry out their role … (DHSS, 1989 para. 1.9)

to ensure that service providers make practical support for carers a high priority. Assessment of care needs should always take account of the needs of caring family, friends and neighbours … (DHSS, 1989 para. 1.11)

While this White Paper focuses largely on the role of statutory and independent bodies in the provision of community care services, the reality is that most care is provided by family, friends and neighbours. The majority of carers take on these responsibilities willingly, but the Government recognise that many need help to be able to manage what can become a heavy burden. … Helping carers to maintain their valuable contribution to the spectrum of care is both right and a sound investment. (DHSS, 1989 para. 2.3)

As far as the consumer right issues were concerned, as already shown in the philosophy section, the Government approach seems to be limited to ‘choice’ in the market without any further measure to make this choice real to the vulnerable client. The attempt to give the purchasing role to the local authorities rather than directly to consumers might be interpreted as their being considered protectors, morally superior than the market, with the interests of vulnerable clients in mind (B. Hudson, 1990). However, as we saw in some criticism, it is unlikely to have substantial meaning with the practical dilemma of care manager with the constraint on resources while facing growing demands.
To live independently in the community while maintaining caring capacity of the community

Citizen
- caring responsibility

Informal carer

Voluntary sector

private sector

Social service department
- Effective and efficient use of resources
- Contract

Voluntary sector
- Contract

Market individualism

Growing social needs
- Lack of collaboration
- Ineffective allocation of resources

Figure 11: The structure of the policy approach in the personal social service reform in the 1980s and the 1990s

Moreover, in terms of the consumer ‘voice’, as seen in the discussion on empowerment as well...
as planning in previous sections, Government consideration of user involvement was limited to ‘within available resources’ and, more importantly, the planning process was found to be considered as a method to control local government rather than to encourage user participation in the text.

Conclusion

Through the analysis of texts in the key policy documents of the Conservative Government in the 1980s and 1990s, the coherent structure of the approach is found behind another profound policy development of personal social services following its establishment in the 1960s and 70s as illustrated in Figure 11. While growing demands on social care from an aging population and social changes were acknowledged by the Government, they did not accept that it was their responsibility to address these demands. They limited their role to strictly within a residual level. Instead the effective and efficient use of available resources was understood as the more serious objective of the government.

This was based on the Government philosophy of familism and consumerism. The family was thought to be the best place for caring, and they should not and cannot be replaced by the Government. So the Government’s job was instead believed to be the encouraging of the development of diverse service providers and competition between them in order to promote better services and choices for the family or ‘the community’ to maintain their primary responsibility of caring. The voluntary sector was more valued for providing a good contribution from ‘the community’. In this context, the right of citizenship was replaced with the obligation for caring as a member of ‘the community’. Their right was defined as the right to choose from what was available.

The ideological choices of the Government in policy reform became ever more evident through comparison with the comprehensive review of contemporary literature on personal social services. Between the arising discussions for alternative approaches to bureaucratic state care provision from different perspectives, the Government rigidly clung to the consumerist option. While there had been various arguments about ‘community care’ what the Government applied
to their policy was the particular combination of community care coherent with their familism philosophy: care in the community based on care by the community. Even though the model suggested by the government-funded case management projects was the ‘complete model’ (Challis et al., 1989), the model utilised by the Government was the ‘administrative model’, which was the minimalist option just requiring the managing of a mixed economy of care.

This coherent set of choices in the policy development of social services shows the visible influence of the political ideology of the Government which was analysed in Chapter 3. Its residual objectives and market individualism in social service policy are evidently associated with the commitment for freedom and the New Right philosophy: ‘to let people (do) what they want to do and (choose) what they want to choose in the market without paternalistic intervention of the state’. The limited managing role of local government in the social care market, not as a provider and but as an enabler is mirrored by the Government’s perspective of the state in the economy – not a player but a referee under their monetarism and emphasis on law and order. The citizenship in the social service shares exactly the same ground with the Government ideology: the right of citizen was defined as the right to buy with primary responsibility on the family.

Consequently, the central role of the ideology on the policy development of social care during the 1980s and 90s seems to be self-evident and the understanding of this influence provides a better understanding of the reform rather than solely considering the environmental factors, such as economic constraint, although it was most significant in this period. As discussed at the beginning of this chapter, the latter could not provide the complete picture of the government’s response to the effects of the continuing expansion of social rights, political expectations and demands on social care accompanied by economic restriction.