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COMMUNITY HEALTH SERVICES:

A REVIEW OF LEGISLATIVE DEVELOPMENTS,
LITERATURE AND THEORY

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1. INTRODUCTION

The 1960's saw an increasing number of Health and Social Service personnel and academics referring to the concept of "Community Care" as a new alternative to hospitalization (or institutionalization as it was sometimes more emotively referred to). The concept, however, was not so "new" or radical as some supposed. Community care in the case of elderly people, for instance, has been the general rule rather than an exception both before and since the establishment of "The Welfare State", with only a minority of elderly persons requiring some form of permanent residential care. A. Hunt (1978) in her national study "The Elderly At Home" found that no more than 6% of the over 65's live in residential homes or hospital accommodation, and that even for very old people (over 85) those living in these institutions accounts for only 21% of the population. These figures are consistent with earlier estimates of the number of elderly people living in a community setting rather than being representative of a markedly successful community care policy.

A defined community care policy is, however, fairly recent, particularly on the scale being envisaged by successive Governments applying not only to elderly persons, but also to the mentally handicapped, mentally ill, physically disabled and some post-operative convalescents previously hospitalized for long periods of time. The evolution of attitudes toward community care and the administrative and legislative structures proceeding from these are interesting to examine. Firstly, legislative and policy developments will be discussed and this will be followed by a review of general trends in thought and practice expressed mainly in academic studies. It is recognized, however, that policy and research are closely related and that this division is therefore somewhat artificial.

2. LEGISLATION AND GOVERNMENT POLICY

In 1598 care of vulnerable groups of the population by the family was actually a statutory duty (as defined in the Poor Law of 1598). Bruce (1961) in his account "The Coming of the Welfare State" cites the following legal clause which remained law for over three centuries.

> "It shall be the duty of the father, grandfather, mother, grandmother, husband, or child of a poor, old, blind, lame or impotent person ------- if possessed of sufficient means to relieve and maintain that person."

Subsequently, the workhouse was available for persons who were destitute or who needed "care" which their families were incapable of providing. It was not until the 1948 NATIONAL ASSISTANCE ACT and the 1946 NATIONAL HEALTH SERVICE ACT, that health care was provided at a level that did not depend on personal or family means. The former was important since it abolished the workhouse and placed upon local authorities the duty to provide residential accommodation for all persons who

> "by reason of age, infirmity or any other circumstances, are in need of care and attention not otherwise available to them."

This was termed Part III accommodation and at the time was envisaged as consisting of small units or "homes" of less than 30 people, to be provided for those in need regardless of their financial circumstances.

In 1945 the Nuffield Foundation established a committee to investigate the problems of the elderly and care of their needs. The recommendations of the Rowntree Committee (1947) formed the basis of the NATIONAL ASSISTANCE ACT (1948). The report is notable in that it gave little attention to domiciliary care and argued that this should remain the responsibility of voluntary organizations and the family since the costs of providing such a service in addition to public expenditure on pensions were considered to be greater than the cost of a place in a residential home. Throughout the 1950's community care was regarded as being that which was delivered in a person's own home and which was adequately provided by voluntary organizations. Further legislation to ensure Local Authority provision was, therefore,

regarded as unnecessary. The types of services which were provided by the voluntary sector were mainly social centres and events with meal-on-wheels being organized by the Womens Royal Voluntary Service (W.R.V.S.) and also provided by the Salvation Army, The Red Cross, and the National Old People's Welfare Committee (N.O.P.W.C.). The inadequacies of this patchy system of meals provision and its geographical disparities were brought to light by Harris (1961) "Meals on Wheels for Old People" - s study sponsored by the National Corporation for the Care of Old People (N.C.C.O.P.). Harris' study of 453 meals-on-wheels schemes throughout the country showed that 40% of the people receiving meals only got one a week. She also revealed that many of the schemes ran for only part of the year; this was particularly likely where they were run in conjunction with other services such as school meals. In his introductions to the paper, the Chairman of the N.C.C.O.P. commented on the results.

> "The scale on which this service should be provided
> to meet all needs is beyond the scope of voluntary
> finance and their resources of manpower."

Following the report, the Government empowered local authorities to provide a meals service of their own in the NATIONAL ASSISTANCE ACT (1948) AMENDMENT ACT 1962. Hitherto, the voluntary organizations had shown considerable resistance, wanting to retain their role in meals provision. Since by the end of the 1970's little over half the local authorities provided meals-on-wheels, it would appear that voluntary organizations still play an important part in this aspect of community service provision.

This was the first of several pieces of legislation to be drawn up on the 1960's which furthered the development of domiciliary health care provision. In 1968 THE HEALTH SERVICES AND PUBLIC HEALTH ACT made it the duty of local authorities to provide domiciliary home-helps on a scale "adequate for the needs of the area" - though this, like many policy statements, is obviously open to variable interpretation. In 1965 the Seebohm Committee was set up. In "The Report of the Committee on Local Authority and Allied Personal Social Services" (DHSS 1968) they recommended that unified social services departments be set up. At this time a number of departments were responsible for

welfare issues which resulted in problems of service inaccessibility (resulting both from bureaucratic control and absolute availability), insufficiently quick recognition of needs and indeterminate boundaries of responsibility. This fragmentation was also viewed by the committee as inhibiting the acquisition of financial resources. Unified departments were justified on the grounds that the concept of "need" was a common focus of concern in the previously separate administrative committees. Need was regarded as being a product of social and community networks rather than being specific to an individual. It was the support of weakened community links, therefore, that was to be the frame within which social services were to operate. The report of the Committee on Local Authority and Allied Personal Social Services (DHSS 1968) marked the first stages of a growing recognition that health care and related social services should be provided on a community basis. Some of its suggestions were realised in the LOCAL AUTHORITY SOCIAL SERVICES ACT 1970. This meant that child and welfare departments were merged and that the home-help service, meals-on-wheels provision, residential care and the supply of aids and adaptations for the disabled were the responsibility of the new Local Authority Social Services Departments. This restructuring was expected to provide services in a way which was more responsive to the needs of the community and it was also hoped that collaboration with other departments such as housing and education would provide a holistic approach to the concept of need. The extent to which this has been achieved is debatable, departments tending to compete with one another for unlimited finance rather than identifying areas of common concern in which their respective interests were complementary.

Another development in 1970 was the introduction of a private member's bill which reached the statute book as the CHRONIC SICK AND DISABLED PERSONS ACT. Previously, care in the community had referred mainly to the elderly. This act required local authorities to find out the numbers of disabled people living in their area, to establish the extent and type of needs, to publicize the available services and also to provide aids and home adaptations. This greatly increased the potential for the disabled to continue living in their own homes and marked the beginnings of a community care policy for the disabled.

Following the establishment of Social Services Departments, there was a similar restructuring of the National Health Service (N.H.S.) in 1974. The aim of reorganization was again to provide an integrated adminstrative structure which would be more capable of perceiving and meeting the health needs of the community. The old tripartite system of Hospital Boards, Management Committees and Executive Councils was replaced by a population based system with regional, area and district levels. A more important development, however, from the point of view of community care was that the Community Health Services which had been provided by the Local Authority Health Committees were transferred to the new Health Authorities. This means that community health services in the broadest sense of the term with which this paper is concerned are now the joint responsibility both of the Social Services Departments and the Health Authorities. Problems of co-ordination were thought to be minimized by establishing co-terminosity between the geographical boundaries of local councils and Area Health Authorities. The Government paper "Patients First" (D.H.S.S. 1982) outlined steps for the removal of the area tier of administration and co-terminosity with some councils no longer exists (i.e. where more than one district constituted pervious areas). The "community" was emphasised in the planning process by setting up joint committees which are described in detail at a later point. Changes in welfare administration then did aim primarily at community-based services though recent developments in the Health Service might suggest that coherent planning for need is being given less emphasis.

Throughout the 1970's there was considerable research carried out into the advantages of community care for different types of people both by academics and Government bodies. Hunt's (1978) extensive study "The Elderly at Home" was mentioned earlier. She highlighted gaps in service provision for the elderly and emphasised the need for greater domiciliary care. Morris' (1969) sociological study of institutions for the mentally retarded revealed the inappropriate placement and poor conditions for the inmates of mental hospitals is also exemplary. Under the editorship of Sutherland (1971) a collection of papers describing the merits of community care for the mentally handicapped provided by a mental handicap team illustrated another aspect of this policy.

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Also important in guiding Government policy at this time were a series of revelations about cruelty in mental hospitals. Malpractise at Ely Hospital, Cardiff was first reported in 1967 by "The News of the World". Later, there followed an enquiry into the conditions at Farleigh Hospital which resulted in the conviction and imprisonment of 3 male nurses for cruelty to patients. These developments, together with research reports (which are discussed in more detail in the relevant sections below) precipitated two Government white papers in the 1970's which expounmded current Government policy for the mentally handicapped and mentally ill. BETTER SERVICES FOR THE MENTALLY HANDICAPPED (D.H.S.S. 1971) explicitly stated the belief that the appropriate place for care of the mentally handicapped was in the community.

"Each handicapped person should live with his family as long as this does not pose undue burdon on them or him; and he and his family should receive full advice and support."

In 1979 the Jay Committee (Chairman Peggy Jay) concluded after a period of research into care for the mentally handicapped that the following components should be an integral part of policy.

1)   That they have a right to enjoy normal patterns of life in the community.

2)   That mentally handicapped people have a right to be treated as individuals.

3)   That they will require additional help from the communities in which they live and from professional services if they are to develop their maximum potentials as individuals.

The committee also recommended that where residential care was needed, small family-type groups run on an informal basis were most appropriate.

Thus we can see an increasing amount of attention and corresponding adjustments in Government policy and service organization being given to the emphasis on "the community" as the most appropriate location for the treatment and delivery care. The application

of this to different categories of people has been mentioned. In the hospital sector, those in need of care are termed patients. In social services and community health services the appropriate terms if "client". Butterworth and Skidmore (1981) elaborated this distinction.

> "Remove a patient from the hospital and he becomes
> a client. Initially by offering him treatment at
> home or within his community there is the implica-
> tion that he is not severely ill."

Within a community care policy services have tended to be provided on a client type basis rather than being broadly applicable. Usually services are planned for client groups which have been referred to but as yet left undefined. Fig. 1 lists those client groups usually defined by health and social services.

Fig. 1 MAJOR CLIENT GROUPS

1.	THE ELDERLY
2.	THE MENTALLY ILL
3.	THE MENTALLY HANDICAPPED
4.	THE PHYSICALLY HANDICAPPED
5.	THE SENSORILY HANDICAPPED
6.	MATERNITY
7.	CHILDREN

These groups can also be further sub-divided according to levels or types of disability. Community care is usually mentioned in reference to those groups for whom institutionalization was previously a popular mode of care (the first 4 groups in the above table).

The concept of community care has not, however, been consistently defined within the minds of the Government and planners in Health and Social Services. The assumed benefits have also defied definition. During the 1950's and early 1960's community care was seen as a means of relieving the pressure of increased demand for hospital care. Towards the end of the 1960's the emphasis was on deinstitutionalization and the provision of domiciliary care as a positive and beneficial alternative to the dehumanizing environments found in hospitals and residential homes. The Government paper "Socal Care Research"

(D.H.S.S. 1978) defined a primary objective for the care of the elderly as the development of domiciliary provision and the encouragement of measures designed to prevent or postpone the need for long term care in hospital or residential homes. A year earlier, however, in "The Way Forward" (D.H.S.S. 1977) the definition of community care was stated as covering a wide range of service provisions which included community hospitals, hostels, day hospitals, residential homes and day centres in addition to domiciliary care indicating a broader definition including some institutional care. In the paper "A Happier Old Age" (D.H.S.S. 1981), yet another facet of community care was emphasised, which revealed a belief in the shift of responsibility of care provision from the state to the family and friends of the client. The D.H.S.S. stated that:-

> "care in the community must increasingly mean by the community."

Peter Abrams (1980) summarised the new definition of community care as:-

> "provision of help; support and protection to others by lay members of societies acting in everyday domestic and occupational settings."

It would appear, therefore, that this view of community care is a return to the situation in 1598 when care was the statutory duty of family.

A further trend in academic and Government research has been to question the rejection of detrimental residential care with the suggestion that for some, life in a residential home or long stay hospital ward may provide more community links than would be found for some living along in their own homes. This view, however, is not held universally and some maintain that being surrounded by other people does not necessarily remove the experience of loneliness and isolation. One of the recommendations of the Black Report (D.H.S.S. 1981) was that a re-emphasis on "appropriate" care was needed rather than blanket policies.

> "We therefore recommend that the present function and structure of hospital, residential and domiciliary care for the disabled elderly should be reviewed in relation to their needs in order to determine the most economical balance of services."

The most economical balance in terms of public expenditure is where the emphasis is on those services provided "free" which might offer some explanation as to why "care by the community" has recently been stressed.

The gradual acceptance and implementation of community care policy is inextricably linked with the changing definitions of its components. It would appear that definitions of "community care" are offering a response to economic expediency rather than showing a firm belief in the merits of applying a particular policy to the needs of individual clients. MacIntyre (1977) expanded this point by stating that:-

> "Community care is a form of human rhetoric masking a desire to control public expenditure on the elderly."

It may be quite a plausible hypothesis that community care has been used as a justification for excluding certain client groups from highly expensive services, particularly considering that such a policy is directed primarily at "non-productive" sectors of the population - mainly the mentally handicapped, mentally ill and elderly in need. One justification for the provision of a National Health Service was the need to secure productivity levels by maintaining a healthy work-force. It is necessary, then, to explore not only the policy trends and definitions but also the factors and assumptions on which such a policy is based. The theoretical concepts upon which community care is based are expanded in a later section.

3. THE ACADEMIC VIEW

3.1. Introduction

Academic researchers into social policy and practice have had a dual role. Firstly, they provided material for the debate from which community care policy emerged, and secondly they have monitored and evaluated the implementation of that policy. Most of these studies tend to concentrate on separate services or on a package of services to a particular client group, most

commonly the elderly in need. Some of these studies will now be reviewed. They represent only a sample of the available literature. Although most of the studies are directed towards a particular aspect of community care, a rigid classification of the literature would be misrepresentative of the wider comments and generalizations made in some papers. The categorization used below, then, is intended merely as a means of structuring the discussion not as taxonomic labels.

3.2. Domiciliary Care

The two main forms of domiciliary care that have been studied are the home-help service and meals-on-wheels provision. These are the responsibility of the Social Services Departments; somewhat less attention has been given to home nursing, health visiting and chiropody as domiciliary services provided by the health authority.

3.3. Meals-On-Wheels

Connelly and Goldberg (1979) reviewing the state of research on meals-on-wheels concluded that there was a wide range of standards and patterns of provision and that a general uncertainty still existed over the objectives of the service. They also stated that there was also a lack of review of need for the service once clients had been referred and accepted.

Various aspects of the meals service have been investigated such as the number of meals that should be delivered per week; the nutritional content and the form in which it should be presented (e.g. by Armstong *et al* 1980, for the D.H.S.S.); the charges for meals and the organization and appropriateness of the service in meeting needs.

A consumer survey by Johnson *et al*(1980) suggested that most recipients express satisfaction with the meals[1] but between 1/4 and 1/2 would like to see the service expanded[2], that is to receive more meals per week. Robin Means (1981) looked at the political background to the meals-on-wheels service. He

concluded that the service should be limited to clients in need of meals rather than the present "open door" policy, particularly in view of the financial constraints in local government and the growing numbers of dependent elderly people. Challis and Davies (1980) expressed this concept in a more general application to all community health services. A recurring theme in studies of meals-on-wheels (and indeed all community health services) then, has been the necessity of establishing more rigorous service objectives and definitions, thereby clarifying the "need" and eligibility criteria for service allocation. This problem is discussed in a later section.

3.4. Home-Helps

The home-help service is one in which a more detailed consideration of the needs and disabilities of individual clients already exists. Several studies have been concerned with reviewing or constructing composite "need indicators", others with monitoring the effectiveness of need assessment in securing the allocation of home-helps to the most dependent clients. Generally the results show a close correspondence between service allocation and the needs of clients. Bebbington (1979) looked at the changes in service provision to elderly persons over a 14 year period and concluded that the extra domiciliary services created during the late 1960's and early 1970's went predominantly to those people who were over 80 or who were severely incapacitated. Boldy and Howell (1979) from their study of the home-help service in Devon also found that in general, home-help provision increased with a client's disability, for those who were unable to pay for the service, for those living in housing with poor amenities and for those clients who could be medically defined as "confused".

The administration of the home-help service has been studied at a number of levels. The role of the home-help organizer is consistently emphasised and it appears that the quality of the service and the extent to which the home-help

service has been expanded in terms of coverage and role redefinition, is to a large extent dependent on the personal characteristics of the organizer and his or her efficiency in dealing with the workload.

An experimental project which explicitly sought to enrich the role of home-helps was carried out in Coventry and reported by Latto (1980). The improved service was implemented in one area of the city and the outcome of clients compared to those resulting from the traditional system in a control area. The results were quite surprising as the project clients were found to use more related services than those in the control area. Rather than being due to an inadequate home-help service, the greater service useage by the experimental group was attributed to an improved, more comprehensive assessment of clients by the home-help organizer and to closer client-helper contact. This facilitated the discovery of hitherto latent needs and therefore greater uptake of community services that could meet them. In the area of community nursing, however, the project clients were found to receive significantly fewer hours per month than the clients under the traditional system of home-help provision. This indicates that the wider role of home-helps in undertaking personal care tasks is acting as a substitute for nursing care. The question of services substituting for one another is, therefore, a complex matter; improvement in one community service could have the effect of substituting for more expensive forms of care but equally it may lead to improved need assessment and a corresponding increase in demand for already thinly spread services. Judge *et al*(1980) reviewed the possibility of charging for home-help services and the form in which these might be implemented. They found that although charging for service could increase Local Authority revenue which could be used to create a more extensive service, these charges would also raise administration costs and increase hardship to those clients who either were unable to pay or suffered relative poverty in doing so.

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3.5. Social Work

Goldberg and Warburton (1979) suggest that between one third and one half of referrals to social work teams in Local Authority Social Service Departments are elderly persons, particularly those over 75 years old, living alone and with problems caused by their physical or mental infirmity. This dismisses a common assumption that most social work is carried out amongst families and children. Within the social work profession, however, there is a clear preference towards cases dealing with children. Howe (1980) investigated the case bases and preferences of social workers. The results indicate that the elderly, and physically handicapped were preferred by only 17% of social workers and those clients who were mentally ill or handicapped the least preferred. Furthermore, the best qualified social workers were most likely to work on cases involving children. This might suggest that certain client groups, specifically the elderly, mentally handicapped and mentally ill, although they constitute a high proportion of the cases dealt with by a social work team, may be receiving less informed, experienced and caring attention. Phillipson (1982) suggested that there may be broader issues at work in the preferences of social workers for different cases. Looking at several studies he considers that the main factors cited for the antipathy towards elderly clients such as difficulty in identifying positive features in a client's life, guilt of being unable to supply adequate resources, and problems of communication, were equally applicable to other client groups. He considers that structural ideological and organizational factors operate to reduce the priority of work with old people. This he sees as being an integral part of the wider political economy and the class structure within capitalism. Phillipson also criticises the passive role taken by the social work profession and their neglect of class and gender relations which has led to serious limitations in the ability of social workers to deal with main factors underlying problems of the elderly.

Several studies have asked the question "What should the role of the social worker be?" The trend has been to emphasise the social worker as a co-ordinator and organizer of service packages tailored to meet the needs of individual clients by mobilizing resources in both the statutory and voluntary sectors. The "Thanet Community Care Project" was an experimental service based on this view and was described and monitored by Challis and Davies (1980). As in the Coventry Home-Help Project, the service was evaluated by comparing clients under the experimental service with clients from a control area. The scheme gave social workers control of a budget which they were encouraged to use to buy established forms of care and for exploring new methods of community care and support. The Thanet project was set up in an area of large numbers of elderly people living alone and was intended to remedy a system considered insufficiently sensitive to individual needs. It represents the implementation of a community care policy in its envisaged form whereby voluntary and social services are intermeshed in a co-ordinated system. Challis and Davies (1980) monitored the outcome on a matched sample from the experimental and control areas. The aim of maintaining people in a community setting was best achieved in the experiemental area - 68% of the clients remaining in their own homes as compared with only 34% on the control group. Furthermore, these results were achieved at slightly lower costs for the experimental group. The community care project has been replicated in Gateshead where a different population structure has meant a slightly different emphasis. There the aim is to reduce the costs of informal care to the family.

Lorna Paterson (1979) examined the role of the social worker as decision maker in the selection of residents for Part III homes. The admission of applicants was found to be dependent on a client's social background and the pressure put on the authorities by their families. However, the social background and experience of social workers were also significant in gaining a client admission. Frequently, the cients of younger social workers were given lower priority when a place in residential care arose. The organization of social work teams

has also been the focus of discussion, the "patch" system (with
social workers working in specific geographical areas rather
than the traditional specialism organization) has emerged as
being the most favourable system for the implementation of a
Community Care Policy. It may be, however, that certain client
groups such as mentally handicapped persons might benefit from
being assigned to social workers with a more specialized
knowledge of their difficulties. The patch system has, there-
fore, been criticised as being wasteful of existing experience
and specializations held by the older social workers. A further
organizational trend reflecting the emergence of a Community
Health Care Policy has been the attachment of social workers to
general practices. This is discussed by Corney and Briscoe
(1977) and Winney and Corney (1982) and represents a step
towards collaboration between Health and Social Services and a
recognition of interrelated needs that do not fit the compart-
mentalized system offered by divided organization.

3.6. Day-Care Services

Day-care spans a range of aims and activities for several
client groups from the fit elderly to the physically and
mentally disabled which can take place either in a specialized
centre, residential home, hospital or community social centre.
Day-care facilities can be run by Health Authorities, Social
Services Departments, or voluntary organizations who may or may
not be acting as agents for the local authority. Day-care then,
represents an area of community health services in which there
is an overlap of provision, users and responsibility. This has
resulted in a rather patchy distribution both nationally and
locally.

There appears to be some confusion as to what the aims of
day-care should be, particularly those of day hospitals. The
general view is that day centres should take a predominantly
social role whereas day hospitals should concentrate more on
rehabilitation and maintenance as a preventative measure to
delay the necessity for full-time hospital or residential care.
Day-care centres, however, have emerged with dual purposes. On

the one hand they are seen as providing an opportunity for
social contact for persons who are reasonably fit and active yet
might feel lonely and isolated and need social stimulation. On
the other hand-day care is seen as preventative and contributing
to maintaining people in the community by relieveing the strain
of caring for their friends and relatives. Where these two aims
are combined in a single facility, conflict can arise.

The National Institute of Social Work (N.I.S.W.) commis-
sioned a broad survey of adult day-care which was carried out
over a period of 5 years (1981). Their sample covered all
client groups for whom day-care is relevant, in 13 local author-
ities. The main finding that emerged from this study was that
those in greatest need of day-care may receive least since their
disabilities make them dependent on the availibility of
transport to the day-care centre. This may not always be
provided as extensively or intensively as required. All studies
on day-care seem to emphasize the importance of transport and
the effect that its provision has on the costs of day-care. A
study of day-care in East Anglia for the D.H.S.S. (Fennell *et al*
1981) indicated that transport constituted 1/4 of the total cost
of day care services. Knapp and Missiakoulis (1980) examined
the provision of day-care by local authorities and voluntary
organizations and their relative costs. The voluntary units
which are usually assumed to have lower costs were found to have
the advantage only below a certain size. For the larger day
centres, those run by the social services departments were found
to be more cost-effective. A more interesting conclusion that
emerged from comparing users perceptions of the services was
that in general, the Local Authority facilities were more appre-
ciated. It would seem, therefore, that Local Authorities may be
providing better quality care. However, the concept of stigma-
tization from the receipt of "charity" may also be operational
in reducing clients appreciation of voluntarily run services.
This highlights a continuing theme in community care policy —
who should provide care — the State, voluntary organizations or
the informal care networks of family and friends and whether
welfare benefits are rights or priviledges. The N.I.S.W. Study
(1981) also investigated consumer views of day care and reported

mostly positive and encouraging comments. All attitudinal studies, however, warn against taking responses at face value, particularly in the case of the elderly since users are generally unwilling to be critical and do not want to appear ungrateful. The same study did show that day care in residential homes was not valued highly and was of inferior quality to care provided in a specialized centre or community building. Day-care has received considerable criticism in the literature on a number of grounds. Carter (1981) in "Day Services for Adults - Somewhere to go" stated that although day services provided a useful opportunity for social contact and a source of variation in clients' lives, the activities that took place were frequently dull and routine. Some studies, however, show that with little imagination day centres can provide a stimulating and learning environment. Goldberg and Connelly (1981) for example, mention a day centre in Caterham where elderly people were involved with helping to make costumes, print tickets, fold programmes, etc. for an amateur theatre group.

Ambiguity over the role of day hospitals has also been highlighted in the research. The National Institute of Social Work Study showed that day hospitals were not meeting their modest objectives and that the proportion of time given to treatment was relatively small. Martin and Millard (1978) in a study of hospitals in the South West Thames region entitled "Day Hospitals for the Elderly - Therapeutic or Social?" found that:

> "At 1/3 of the units less than ten minutes, and
> at 2/3 less than twenty minutes of time was
> available per day. This hardly justified the
> claim made by all bar one geriatric day
> hospitals that physiotherapy is a major reason
> for attendance."

For the majority of the time, therefore, day hospitals act a social facilities for clients. If it is a social centre that is being provided then the costs of hospital provision should be compared to costs of Local Authority provision and any wastefulness of resources eliminated.

The organizers of day-care services also have to consider the characteristics of clients that should be provided for in a single centre. In the case of the elderly, for example, the research indicates that clients who are mentally alert do not mix well with those who are "confused" and separate provisions which emphasizes social contact for the former group and care and re-orientation for the latter might be preferrable. However, some experiments have shown that integrating different ages and disabilities can facilitate an awareness of the problems of other people and an interaction between the attenders which helped to blur the role of carer or helper and "patient" (G. Reed 1979).

The role of day care in the package of services which constitute "community care" seems to be poorly documented. Goldberg & Connelly (1981) reviewing the literature on day-care in "Effectiveness of Social Care for the Elderly" stated that most of the studies were descriptive and that few looked at the effectiveness of day-care as compared with other forms of care, or its relationship to other services.

3.7. Assisted Lodgings

These are only available on a limited scale at present but recently have received renewed interest as providing an alternative source of care to certain client groups. Accommodation is provided in private homes with someone who is prepared to give greater support than is normally expected of a landlord or landlady. The lodgings can be either on a short term basis to provide relief for a dependent's family or during convalescence, or they can be on a more permanent basis for those who perhaps have no home or have been released from an institution and are not immediately able to cope independently in the community.

A study at the University of Leeds by Thornton and Moore (1981) on the placement of the elderly in private households was an extensive review of the system in England and Wales. They found there to be 285 short stays in 1979 but only 23 schemes existing in that year. The small number might be an indication

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of schemes being only in the experimental stages at present. The researchers recommended that assisted lodgings were better tailored to short term care, since for long term placement the problem of matching suitable applicants and carers proved considerable. Boarding out schemes or family substitute care which are alternative labels gives to this mode of care, have also been used for psychiatric patients who were previously dependent on institutional routine. C. Smith (1975) reported the discharge of 130 patients from Old Manor Hospital in Salisbury and suggested that supported lodgings could be preferable to placement in a residential or group home for people who could not cope with the social achievements demanded by such environments. The Exe Vale Hospital in Exminster used assisted lodgings to accommodate some of its inmates after a 1962 survey revealed that of the 1,600 patients, approximately half, no longer required hospital care. Private registered homes were also used for these people who often did not fit the admission criteria for Local Authority Part III accommodation. It is likely that with the re-emphasis of community care as being "by the community" that assisted lodging schemes will take a more significant role in providing accommodation for those in need.

3.8. Sheltered Housing

Sheltered housing is accommodation in specially designed or converted property which may be grouped around some communal facilities such as laundry or cafeteria and may have a warden resident or on call through an alarm system. There are considerable variations, however, on the form that such facilities take. The provision of sheltered housing is the responsibility of Local Authority housing departments but Social Services may be responsible for the provision of warden services. Sheltered housing then caters for both housing and social care needs and these can be conflicting if the specific aim of a sheltered housing complex are not well defined.

Several aspects of sheltered housing provision have been studied. The location and design of units has been emphasized as a crucial factor governing the accessibility of facilities

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such as shops and entertainment for the elderly or disabled residents. A second aspect that thas been investigated is the system of allocation. Bytheway and James (1978) and Butler (1978) in his extensive study of 600 sheltered housing tennants found that allocation was frequently on the basis of housing needs as opposed to the need for care and supervision. The more recent study by Butler (1982) however indicates that the age of clients in sheltered housing is related to the age of the housing scheme. The average age of residents who have been in sheltered accommodation for less than one year is now 75.8 years and Butler attributes this increase in average age at admission to be a reflection of a greater consideration of health and need for care in allocation procedures and a diminishing of the significance of housing need.

Behavioural studies on both wardens and clients have been carried out. Duncan Boldy (1976) investigated the individual characteristics and attitudes of wardens in sheltered housing schemes and found that the majority, although the job entailed more work than they were probably paid to do, expressed considerable job satisfaction. Butler (1979) revealed equivalent satisfaction on the part of tennants. Strikingly he found that housing association schemes were rated higher by residents than Local Authority sheltered housing schemes.

One of the main themes to emerge from reports of sheltered housing schemes is the questioning of the aims and objectives of sheltered housing provision. If the main need is for housing, perhaps resources might be better invested in improving and adapting the existing housing stock associated with the elderly and disabled. On the other hand, if social care and supervision is the primary need, then informed residential care may be a more appropriate way of securing this. The assumptions underlying the provision of sheltered housing accommodation for "discrete" client groups such as the elderly (who constitute the main beneficiaries of such schemes) have also been questioned. The elderly, for example, are only unified by virtue of their age. Their grouping belies a tremendous social, physical and attitudinal heterogeneity that exist in any age grouping of the

population. To some extent, however, residential care takes this assumption further in supposing that communal living is possible and desirable. At least with sheltered housing there is the opportunity for greater privacy and choice in the use of communal services. Sheltered housing, however, is an important community resource and a counter to the above arguments is that it is catering for inter-related social needs and that more schemes which satisfy a continuum of needs should be set up rather than those that arbitrarily define personal problems into rigid causal categories.

3.9. Residential Care

On the 31st March 1980, there was a total of 128,134 persons of all ages living in Local Authority residential accommodation, plus many other people living in private or voluntary-run homes. Compared with Butler's (1983) recent estimate of the number of people living in sheltered housing (400,000 in 1980) this is a comparatively small number. However, when one considers that residential accommodation (for all client groups) accounts for 20% of the total expenditure of Local Authority Social Services Departments, it becomes an important item to consider. There has been much debate on the place of residential care within a community care policy. At different stages of policy definition it has been included or regarded as alternative to community care. Generally the Health Authorities regard Community Health Services as non-hospital care and, therefore, include residential care, whereas local authorities see community care as being non-residential and therefore restrict their definition to domiciliary and day care. These definitions of community care were discussed in an earlier section. The bulk of the research on residential care adopts the definition used in local government.

The seminal text on residential care was Peter Townsend's (1964) "The Last Refuge". His anti-institution stance was taken up in several other studies in the 1960's which provided fuel for the community care debate. Townsend's main criticism of residential care for the elderly and its re-iteration by Oswin

(1973) who looked at residential care for mentally handicapped children was ot the depersonalizing environment and routinized existence. Townsend's (1964) recommendation was at the time, radical but has gradually become embodied in social policy. He suggested the need for:

> "A number of far reaching proposals to reduce progressively the number of community homes and to replace them in part by sheltered housing and in part by a slight extension of the hospital system --- to enlarge greatly the domiciliary services, mainly by creating a Local Authority family help service and to develop greatly general practitioner group practices."

The quality of life in residential homes which received considerable criticism in the 1960's was investigated in depth in the early 1970's. Goffman's (1971) theory of institutions has been widely applied in this context. The theory identified qualities of institutional life as consisting of daily activities conducted in the same place under the same authority with large numbers of people engaged in similar occupations. The timetable was routinized and imposed on inmates by formal ruling. The activities and routines Goffman considered as constituting a plan which was designed to fulfill the official aims of the institution. Wing and Brown (1970) used these qualities in a study of schizophrenic patients in 3 hospitals to show that the social conditions of the institution were contributing to patients' withdrawal and introversion. Michael Meacher (1972) emphasised a different aspect of residential care in his critique of separatist provision for the elderly mentally infirm and advocated a switch to care in the community and the beneficial therapeutic environment provided by family and friends.

Towards the end of the 1970's questions began to be raised about the legitimacy of blanket criticisms of all residential care as being undesirable. Roger Clough (1981) described his observations of life in an old people's home over a period of several weeks. He found that for many residents the home produced care and services that were not possible or available

in a domiciliary situation. For this reason he claimed that it
was not valid to judge life in residential care in terms of the
extent to which "normal" life patterns were followed, i.e. those
which would be experienced in one's own home. Community living
in a residential home provides a different lifestyle and there-
fore different benefits to those which arise from independent
living. Grundy and Arie (1982) added their evidence to this
claim. They found the average age of elderly residents in Part
III accommodation to be 82 and that by this stage most of the
residents were in need of considerable care and supervision.
They concluded that:

> "Institutional care exists because it is the
> most cost effective way of looking after groups
> of people with similar disabilities."

In the same article having accepted the continuing role of
residential care, they also expressed concern for the falling
rate of provision of Part III accommodation. Their calculations
show that there was a 7% fall in the rate of provision between
1976 and 1977. That this trend will continue was suggested by
the D.H.S.S. (1981) "Report of a Study on Community Care" who
mentioned a decrease in both Local Authority and voluntary-run
residential accommodation - the latter being reduced as Local
Authority support for residents in voluntary and private resi-
dential homes is diminished. It would appear then, that at a
time when a niche for residential care is being accepted within
the continuum of care for disabled people, resources are being
withheld and the "alternative" community care being cited as a
more worthy competitor for scarce financial resources. Plank
(1978) supported the role of residential care after his study of
the service in six London boroughs and concluded that residen-
tial care need not be thought of as "The Last Refuge" as it was
dubbed by Townsend (1964). Plank's investigation showed also
that domiciliary care in many cases resulted from expedience due
to the lack of supply of residential care accommodation or
sheltered housing. Thus the tenor of social policy research has
been moving towards the notion of "appropriate" placement or
care. Plank's results also showed the necessity for such an
approach. Just over 50% of the elderly in residential care

within the research area were assessed by social workers to be capable of looking after themselves. It was also mentioned, however, that 40% of those on the waiting list could not look after themselves but that this figure could be reduced by 1/4 if adequate domiciliary care were available. Perhaps then, residential care has fallen into disrepute not because the concept is wrong but from a combination of poorly defined admission criteria and unimaginative organization and administration within individual homes. Rather than viewing facilities or modes of care as pure substitutes for one another it might be preferable to regard domicilary care, sheltered housing and residential care and schemes which fit somewhere between these categories, as constituting a continuum of care intensities appropriate to clients of varying needs and disabilities.

If the notion of appropriate care is accepted then well defined need criteria are required in order to evaluate and decide upon the relevant location and mode of care. Neill (1982) looked at admissions to Part III accommodation in the Greater London Council (G.L.C.) to see if any such need criteria were operational. Her enquiries showed a wide variation in admission procedure and that assessments of a client's need was frequently ambiguous and highly subjective. The method of dealing with waiting lists and "priority cases" was also variable. Neill (1982) also found that some homes operate a "swap" system with a hospital and this can often take precedence over more urgent admission needs in the community.

Attempts have been made in different studies to try and classify residential homes in order to identify some of the more beneficial aspects of some of the homes. The organization of residential care ranges from restrictive systems where staff dominate the running of the home and any decisions governing its daily and long term operation, to more "permissive" systems which allow greater autonomy to the patients in self care tasks and in decisions which affect the life of their "community". Group homes - small residential units for less than 10 persons with or without residential staff are becoming more widely adopted particularly for mentally ill people. Peace and Harding

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(1980) compared the progress of two residential homes for the elderly before and after one of the homes underwent a change in organization to group living. They found that after this step had been taken there were attitudes of greater self-determination amongst the residents and an increase in their expectations[1] of the new environment. To some extent, however, this leads to greater dissatisfaction. Ryan and Wing (1980) compared group homes and hostels for the mentally ill and found the accommodation was discriminatory in the types of residents accepted. Group homes were occupied by patients who had been institutionalized with a history of prolonged handicap and a lesser chance of achieving independence. Hostels, however, tended to accept younger, less handicapped people who might be more active and need greater supervision, they tend to represent more transitional accommodation than a "home". In some areas of health and social services then, a notion of appropriate care location may already be at work. There is still a danger, however, of making sweeping assumptions about the benefits of different modes of care without thoroughly considering the aims of care provision and of general concepts above their implementation in the real world. Residential care at present seems to be regarded as an alternative to community care but no longer one which is always inferior, rather it is viewed as catering for clients of greater disabilities than can be accommodated by caring for them in their own homes, considering the mental and physical strain of the client, his informal carers and the financial costs involved.

3.10. Broader Based Studies

In addition to studies which have focussed on one particular service or client group, there have also been some broader approaches to community care evaluation of which two main categories can be identified. Firstly, there is a group of studies that look at the relative costs of different types of community care for persons of varying dependency as compared with costs of hospital or residential accommodation for those people. Secondly, there is that research which tries to establish what the appropriate balance of different care types

should be, recognizing the interdependence of community health services, and thirdly, some recent studies have been published which attempt to describe community care in terms of its relations with the wider political economy and the capitalist state.

The costing of community care has been investigated by health economists such as Culyer (1974) (1979) and Mooney (1978). Both workers suggest that decision-making for financial resource allocation should look at the ratio betwen marginal benefits and marginal costs. Cost benefit analysis and cost effectiveness have also been applied. The problem with these methods is the ambiguous treatment of "benefits". Not only are statements about what the benefits of different modes of care and which people they apply to rather controversial, but to quantify these intangibles is extremely difficult. For this reason benefits tend to be assumed as being implicit in the decisions of professionals and the decisions are then taken as surrogate indicators of the benefits of different services. Even cost comparisons of different modes of care are not without their difficulties. For example, comparing hospital costs with those of domiciliary care is problematic since the published cost estimates by the N.H.S. do not include the cost of capital plant and its change in value through time. With the costs of domiciliary care, the costs of informal care by family and friends should also be assessed; to put a monetary value on intangible effects such as mental or marital strain in a patient's family or loss of leisure or work opportunities is highly subjective and probably not very meaningful. Peter Sainsbury (in Lees and Shaw 1974) exemplified these familial costs which underly the present interpretation of a community care policy. Referral to a community based service in Chichester were compared with those in a more hospital orientated service in Salisbury. A questionnaire survey revealed the existence of a greater burden on families who cared for mentally disturbed patients under the community based system. He found the main costs to the family were financial but that the mental health of the family also suffered. What was found to be crucial to the success of a community care policy was the provision of a community care policy was the provision of

sufficient social support for the family. This could perhaps be taken as a warning to shifting too much responsibility for care back to the family since in the long term there is the danger of producing a deterioration in the mental health of the population.

Wright et al (1981) recognized the problem of costing informal care and support and outlined three ways of treating it. Informal care could be counted at zero cost since it is familial duty; secondly it could be viewed as a real cost since it alters the opportunities for carers to use their own resources such as loss of potential earnings, or thirdly the costs of informal care can be recognized but their value cannot be assessed until the carers can no longer cope and alternative statutory care services are required.

Some studies have looked beyond the assessment of costs and addressed the concept of cost-efficiency or cost-effectiveness. Opit (1977) found that 20% of his sample of elderly people in Birmingham being cared for in the community had costs greater than hospital care (a quarter of those cases, however, were bedfast). In common with some previous studies some of which have already been mentioned, he raised doubts about the validity of a community care as a viable alternative to hospital or residential care for some heavily dependent people.

> "It is quite possible to keep many seriously
> disabled old people at home, but to do so
> without neglect will require a large investment
> in support services. Even then the quality of
> life for some of these patients may be far from
> compatible with any civilized humanitarian
> standards."

Exercises in cost comparisons are, therefore, extremely limited both in accuracy and also in that the costs estimated are representative of the services that are actually received by people; this level of service provision and the spatial distributions of facilities may be far from ideal. A study of relative costs also gives no insight into the respective qualities of care nor to the effects that different modes of care or srvices have on individual recipients. Economics is just one basis upon which to form judgements as to the optimal

form of care; in issues of welfare it would seem preferable to take into account more humanitarian factors such as service outcomes, individual preferences and perceived benefits in addition to indicators of financial sense.

THE BALANCE OF CARE STUDIES

This category of research is concerned with investigating the range of available services provided by the health authorities and social services departments and attempts to construct a basis upon which decisions as to the "optimum" mix of resources can be made considering the possibilities of service substitution.

Bebbington and Davies (1980) proposed a "Territorial Need Index" based on the principle of territorial justice for all sectors of the population (as opposed to specific client groups). An important component of this index are need judgements - descriptions of an individual's state of welfare in terms of the intervention necessary to meet such needs. These are the judgements made by professionals in their treatment of patients. The consequences of need judgements can be expressed as having both costs and benefits and these were seen by the researchers to be the central concepts in establishing an "optimal" and efficient service and resource allocation. Bebbington and Davies recognized the difficulty of establishing what the benefits of service outcomes were but in the absence of direct research took surrogate need definitions from several studies which they consider to contain implicit assumptions about benefits. The main outcome of this study was a mathematically calculated "Need Indicator" which was the total monetary cost implied by the need judgements for a population in a particular area. This framework was then used to define target groups which , when combined with service cost information, could be used as a tool facilitating allocation decisions. The Bebbington and Davies model then is a mechanism for allocating resources with the aim of "optimizing benefits" within constraints of budgets and the principles of territorial justice. The value of this work is limited by taking the judgements of

professionals as to which service is best, and neglecting the complexities of the relationships between service costs, quality and outcome.

One of the studies which Bebbington and Davies (1981) examined to find their "need definitions" was the Balance of Care model developed at the Institute of Biometry and Community Medicine at Exeter University for the D.H.S.S. The balance of care was the equilibrium between alternative forms of health and social services or a "package" of services which could be used to treat similar conditions. The study looked at services to a range of client groups and specifically at the consequences of assumed rates of growth of resources and how these could be manipulated to produce alternative care strategies.

Seven client groups were defined in the Balance of Care Model which on further subdivision gave 120 unambiguous categories. These groups are shown below (Fig. 2) and differ only slightly from those shown in Fig. 1 which were the categories adopted within this study.

Fig. 2 CLIENT GROUPS

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┌─────────────────────────────────────────────────┐
│                                                  │
│     1.   THE ELDERLY                             │
│                                                  │
│     2.   THE MENTALLY ILL                        │
│                                                  │
│     3.   THE PHYSICALLY HANDICAPPED              │
│                                                  │
│     4.   MATERNITY                               │
│                                                  │
│     5.   THE MENTALLY HANDICAPPED                │
│                                                  │
│     6.   SOME SURGERY                            │
│                                                  │
│     7.   CHILDREN IN NEED OF SOME CARE           │
│                                                  │
└─────────────────────────────────────────────────┘
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The elderly, for example, were divided into 24 categories by professionally defined need criteria. Category E14 for instance defined those elderly people who were:

a) ill,

b) in need of rehabilitation,

c) living in good housing,

d) socially isolated.

For each category a set of alternative care strategies is defined from consultation with professionals who are faced with these questions and decisions throughout their work. For category E14 then, the following strategies are listed"
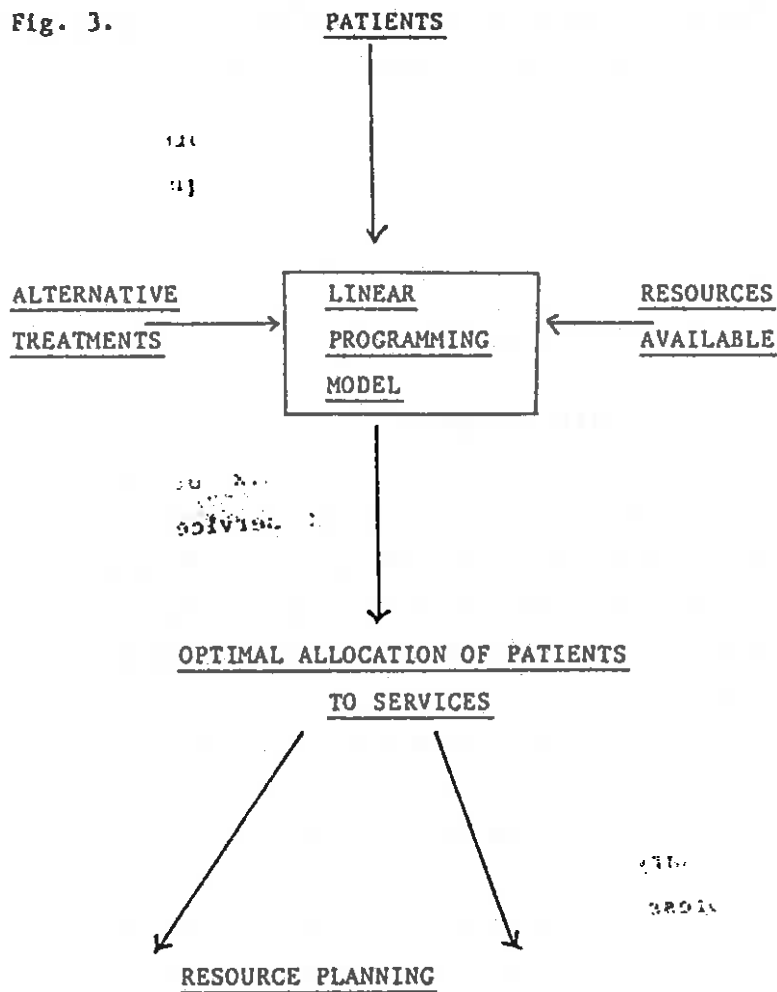
a) admission to long stay hospital,

b) admission to acute hospital,

c) admission to acute hospital with early discharge and a course of treatment at a day hospital, home-help and meals-on-wheels provision.

The diagram below (Fig. 3) illustrates how these alternatives, together with information on the total resources available and those allocated to the different client groups, total numbers within each care type, etc. is dealt with by the model. The model was run cyclically, initially using 1975 data as a base model against which to evaluate subsequent runs in which resource forecasts and other assumptions were varied to identify possible outcomes.

In

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Fig. 3.

PATIENTS

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ALTERNATIVE                    ┌─────────────┐                RESOURCES
                               │  LINEAR     │
TREATMENTS         ─────────→  │  PROGRAMMING│  ←─────────    AVAILABLE
                               │  MODEL      │
                               └─────────────┘
```

OPTIMAL ALLOCATION OF PATIENTS

TO SERVICES

RESOURCE PLANNING

e.g. Personnel training
     Building adaptations
     Supplies, etc.

(JACKSON + HIMATSINGANI 1972)

By cyclical runs of the model using a simulation method, the transfer of patients through different dependency states and treatment locations can be represented. Then through identifying queues, waiting lists and resource constraints, resources can be reallocated within the system to improve the coverage or cost efficiency of the system. Canvin and Boldy (1976) describe the use of the model in Exeter to evaluate present and future service allocations in health and social services assuming no change in the absolute levels of provision and that the present

levels were maintained. The outcomes were compared to the normative levels issued by the D.H.S.S. and services ranked to show those which were most over or under provided. There are a number of assumptions upon which the model is based which can be questioned.

a) Listed Care Alternatives

The list refers only to statutory provided forms of care and even these may not be an exhaustive set of possibilities. Although it is recognized that the terms of reference of the model was statutory community health services in some areas the availability of voluntary services may influence the statutory services allocated. In view of the present emphasis on informal and voluntary care within community care policy, it would seem necessary to take these into consideration. Furthermore the alternatives listed are assumed to be of equal quality, that is as perfect substitutes for one another. The outcome of services and their perceived benefits are considered only implicitly in the definitions of alternative care packages by professionals.

b) Cost Assumptions

Costs are assumed to be linear and relate only to the level of resource inputs. If alternatives are to be accurately considered, the relative costs of provision or non-provision to individuals and the wider community should also be assessed.

c) Service Levels

No statements of the levels of services such as meals-on-wheels or domiciliary nursing which constitute alternatives or substitutes for hospital care are provided. In some cases, however, it will depend on the quality of the services and the particular disabling qualities of a patient; the home-help service is exemplary of this.

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d) Decision-making

The model assumes that social conditions, i.e. "needs"
are more significant than diagnosis in the allocation of
place and type of treatment. Needs are medically defined
concepts in health and social services and are, therefore,
subjective. The personal characteristics and opinions of
General Practitioners and social workers faced with
decisions as to how to allocate and ration scarce resources
may be more influential than some pseudo-objective indicator
of a client's needs. The following factors will affect the
allocation decision.

    i)   Age and experience of decision-makers

    ii)   Personal characteristics and beliefs

   iii)   Knowledge of available statutory and non-statutory
        services

    iv)   Quality of collaboration with different service-
        delivery agencies and their own welfare team

    v)   Motivation and job satisfaction.

By neglecting the diagnostic and decision-making
process in allocation, the model is assuming that staff
behave in a normative way.

A further factor which may affect the allocation of a
service or package of services to a client is his or her
residential location relative to care delivery locations or
facilities. In the case of the disabled elderly, attendance
at a day centre is determined not only by the availability
of the service and the client's needs, but also by their
place of residence and the availability of transport.

e) Uncritical Acceptance

Whilst some of the above deficiences of the model are recognized by some of the academics who developed it (Jackson and Himatsingani 1972) a more general and perhaps serious criticism of the model can be made. The model depicts the existing situation and the possible shifting of resources produced only minor changes in a system which may be inadequate and unresponsive to the real needs of different clients.

Another study which dealt with "balance of care" issues was carried out by Mooney (1978) in Aberdeen. Mooney focussed his attention on "marginal individuals", i.e. those elderly clients who were close to the boundaries between different care locations which were their own homes, residential accommodation, hospital and sheltered housing. Mooney aimed to maximize the "benefits" to the elderly by equating marginal social costs with marginal social benefits in each care location. This method was mentioned previously in the discussion of costing studies. Mooney's method is essentially a consideration of costs. His recognition of the need to analyse benefits is quickly dismissed as being too difficult to measure. Benefit determination is problematic according to Mooney for three reasons. Firstly, there is the difficulty of who is to measure the benefits, the client, his or her family or the health care professionals, and to assessing to whom the various benefits relate. Secondly, the poor knowledge of outcome of different services, and thirdly the great cost of obtaining information about service outcomes and benefits to all the various disability groups is prohibitive.

THE POLITICAL BACKGROUND TO COMMUNITY CARE

The third group of broader based studies is also the most recent. The starting point is a criticism of the majority of social policy research which concludes that more Government and voluntary services and informal care will secure adequate

service levels. Phillipson (1982) in "Capitalism and the Construction of Old Age" maintains that

> "the logic of capitalism as a productive and social system is irreconcilable with meeting the needs of elderly people."

He also criticizes the lack of research on class and gender relations underlying the analysis of old age as a social problem and the policy and treatment addressing that problem. The inequality of informal care falling predominently on women has been given some attention in the literature though the explanation for this is generally ignored. An Equal Opportunities Commission survey (1979) for example, found that in the case of elderly persons, they were three times as likely to live with married daughters as married sons. This was commented upon in the published results.

> "By curtailing her activities outside the home in order to care for her elderly relative, a woman may risk her job, financial difficulty, social isolation, and deteriorating health. The burden of caring can be heavy indeed."

(Equal Opportunities Commission 1979)

Robin Means (1981) in the conclusion to his paper on the politics of the meals-on-wheels service, makes a similar comment.

> "At the moment the allocation of domiciliary services at a local level seems to reflect a belief that daughters ought to provide shopping, cleaning, laundry and cooking for their frail relatives irrespective of their other commitments."

Finch and Graves (1980) expand this point in a paper entitled "Community Care and the Family – A Case for Equal Opportunities" and suggest that at a time of growing demand for services due to demographic factors and of social service cuts and limited health service expansion, long term unemployed persons may be equated with the availability of a caring community. Married women or the "young" fit elderly in particular are likely to be thought of as a "low cost solution" to the difficulties of welfare provision on a truncated budget.

The emphasis by successive governments on the use of unpaid
carers described for example in "Care in Action" (D.H.S.S. 1979)
and "Growing Older" (D.H.S.S. 1981) indicates that this trend in
the present situation of uncritical acceptance of the desira-
bility of a "Community Care Policy" is likely to continue.

3.11. The Voluntary Sector

The role of the voluntary sector in the meal-on-wheels
service and on a general level has been mentioned above. The
nature and extent of the voluntary services as revealed in the
literature must be reviewed in greater detail, however, to
complete our outline of available Community Health Services.
Recognition of the role of the voluntary sector has been
variable and is related to the changing definitions of
"community care" and to politically determined views on the
appropriate role of the State in welfare provision. The present
attitude toward voluntary organizations in social policy is
summarized inthe Wolfenden Report (1977) and the subsequent
"consultative document" published a year later. This is in line
with Government white papers (D.H.S.S. 1978 and 1981) which view
voluntary and informal carers taking a more active role in the
belief that "care in the community should increasingly be by the
community" (D.H.S.S. 1979). "Care in Action" (D.H.S.S. 1981)
indicated that the voluntary sector and the statutory services
should have the aim of supplementing natural family care net-
works.

To refer in general terms to "the voluntary sector" is to
neglect considerable variation in the objects of interest and
methods of organization amongst the numerous voluntary agencies
which exist nationally and locally. Several attempts at
classifying voluntary organizations have been made. Beveridge
(1948) classified philanthropic agencies into 17 categories
according to particular group needs being catered for. This,
however, results in minute sub-division due to the very special-
ised nature of some organizations. Unell (1979) also used a
need based system and identified 4 groups.

i) Age-related organizations – children

                             – the elderly

ii) Handicap-related organizations

iii) Groups concerned with certain social states such as the National Council for Single Women and Her Dependents

iv) Occupationally-orientated groups.

It can be seen that these categories are by no means exclusive. Murray (1969) suggested a classification could be based on an organization's style or mode of operations. For example, caring, self-help and pressure group functions could be used. Gordon and Babchuk (1966) used 3 variables to fit organizations into a continuum based on their membership, organizational status (national, regional, local, etc.) and their function. Hatch (1980) used a variation of this system based on an organization's main workers, state interest, and source of findings. Pinker (1971) classified agencies in terms of whether they resulted in stigmatization or status enhancement of their clients though this is obviously highly subjective. The Wolfenden Committee (1978) considered that no classification was suitable for all purposes and it would seem that failure to produce a system with unambiguous and exclusive categories might be due to the ad hoc nature of the voluntary sector consisting of a continuum of interests and methods of operation. For the purposes of this study only those voluntary bodies which provide a service will be referred to, though this is not intended to belittle those groups who act in the areas of information dissemination, research or as pressure groups.

Throughout the 1970's the number of voluntary organizations and their scope of interest increased dramatically. A number of factors have been suggested as explanations for this. Doubts about the capabilities of Health and Social Service professionals, for example, might explain the initiation of alternative self-help groups. Ivan Illich's "Medical Nemesis" (1977) and its recent expansion in "Limits to Medicine" (1977) expresses a

radical view of the dangers arising from the professionalization and mystification of the medical care system and support for self-care. Public expenditure cuts and their results on the quantity and quality of available statutory services have also been suggested in that voluntary organizations formed in order to fill the gaps betwen needs and State provided resources to meet them. Between 1973 and 1977, for example, the General Household Survey (G.H.S.) showed an increase in voluntary work from involving 8.1% of the population to 9.6%. This explanation of the growth of voluntary services is, however, refuted by Hatch (1980) who found that the expansion predates public expenditure cuts. His study revealed that many voluntary organizations were initiated by staff in statutory posts (such as social work) either as part of their duty or because they recognized a gap in State provision which needed covering. It appears then, that voluntary services have in part delveoped through conscious intervention from the statutory sectory. Unell (1979) showed that between 1972/73 and 1975/76 grants from local authorities to voluntary organizations increased from £2.5 million to £8 million which seems to support Hatch's observations. Voluntary sector development can also be viewed as integral to the wider "consumer movement" at this time which sought representation of minority groups; in this instance perhaps those whose special needs could not be met in the statutory system.

The analysis of voluntary services in the literature tends to be of their role in relation to State services. The Aves Report (National Council of Social Services and National Institute for Social Work Training 1969) for example, looked at the role of volunteers in the social services. They made the point that social work attitudes to the use of volunteers were too cautious and that more effective use of this labour should be made. However, they also mentioned that

"the volunteers should not be regarded as substitutes for professional workers."

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Holme and Maizels (1978) found that less than two fifths of social workers used volunteers in designing care packages for their clients and those that did assign tasks to volunteers rarely had any direct contact with them. Furthermore, the volunteers tended to be used only for befriending clients and some practical tasks and rarely for child care of personal care jobs. Leat *et al*(1981) looked at collaboration between statutory services and voluntary organizations and found that at a general level there was an exchange of funds and information but any system of planned integration of the voluntary services in local policy was not in evidence. Several papers have argued for the importance of integrating the role of voluntary services in Government policy in more explicit terms. Gladstone (1979) saw the need for a system of "gradualist welfare pluralism" and the Wolfenden Committee (1978) also appeard to be in favour of such an approach. Personal social services have always been made up of a "mixed economy" balanced between statutory, voluntary, private and informal provision. "Gradualist pluralism" is one of these frequently mentioned phrases, rarely explicated or justified. Pluralism could be considered as the addition of voluntary services to those provided by the State, or as a partial replacement of existing services so that a statutory-non-statutory mix is achieved or it could be seen as gradual and then total replacement of State run services in selected areas of welfare. The position of voluntary services within Community Care policy may be referred to in general terms but is still ambiguous.

The emphasis of informal care networks supported by voluntary and State services has been criticized on the grounds that notions of the family and community are nebulous. Rein (1970), for example, stated of community

"The term is meant to cover all persons and interests and is not defined."

Research has shown that the geographical definitions of "neighbourhood" have limited use. The variability of "neighbourhood care" schemes is an appropriate example. These were first set up in 1976 by David Ennals (then Secretary of State

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for Social Services - Labour) for the purpose of sustaining and widening the natural helping networks in the community. The emphasis was on the use of local volunteers, but practice has shown that there were considerable problems in recruiting volunteers from predominantly working class neighbourhoods, and that middle class volunteers from adjacent areas have been "imported". In some projects such as in Islington, token payments were made to enable participation though they were not intended as incentives. However, this can create social cleavage between paid working class volunteers and middle class persons giving their time for free. The spurious concept of "community" is discussed in a later section.

Another aspect of Voluntary organizations which has been studied is the area of evaluation. Shenfield and Allen (1972) looked at a sample of 120 old people in 12 local authorities in order to assess the effectiveness of visiting by volunteers. Similarly, Hadley reported in Leat *et al* (1981) looked at young volunteers visiting elderly people. Both studies revealed a tendency for haphazard assessment of clients and a random allocation of volunteers so that often those people who were most isolated were not allocated a visitor. The former study found that in 41% of cases the visits had little or no positive effects on the elderly person. Hadley (1981) found that the most "successful" contact occurred when more than the average number of visits were made, where these were on a one-to-one basis and were religious affiliation provided a common interest. Barker (1979) reported an unpublished study by the Tavistock Institute of Human Relations which investigated a voluntary project run by MIND for mentally disturbed young people who had become dependent on institutional living. The main aim of the project was rehabilitation but its outcome is poor in view of the fact that only one third of attenders were rehabilitated into the community, the rest drifted away or were re-institutionalized.

One area that has received little attention is evaluative comparisons between voluntarily provided and statutory services. It would be interesting, for example, to discover the

effects on residents of life in a residential home provided by
the Local Authority and the experiences felt by residents in a
voluntarily or privately-run home.

In the absence of any direct statutory control over
voluntary services, it seem likely that bias might emerge in the
coverage of services to particular sections of the population
which may reflect a deficit of state provision being covered or
a vested interest on the part of active volunteers.   Unell
(1979) looked at the financial resources of voluntary social
services and found that generally children's organizations are
the best funded.   In her sample of nationally organized bodies
she showed that these accounted for 38% of total expenditure and
that even spending related to handicapped persons tended to be
concentrated on the younger age groups.   Bearing in mind the
earlier comment on case work preferences in social work, this
over-emphasis on children may result in discrimination against
the elderly and handicapped section of the population.

Finance within client groups shows priority given to resi-
dential services.   Residential care is a high consumer of
resources but also guarantees income from local authorities to a
voluntary body.   Unell (1979) warns that there is a danger of
residential homes being established by voluntary organizations
to secure funds since these homes are becoming an outdated form
of service provision.   Webb and Wistow (1982) confirm this trend
and identify policies of internalization whereby local author-
ities are tending to use their own facilities and limiting their
use of voluntary residential provision previously run on an
agency basis.   The results of such policies being applied were
apparent in vacancy rates in voluntary-run homes and of severe
financial pressure in these organizations in some areas.

From this brief review of voluntary servies and some of the
studies which have been concerned with their description and
analysis, it begins to be apparent that the role which the
voluntary sector is expected to take should be made more
explicit and embedded within policy.   This would clarify future

funding possibilities for the voluntary organizations themselves, whilst also guiding Health and Social Service's planners at a local level as to how they can mesh the two systems together. The flexibility and variable characteristics of voluntary organizations probably means that detailed planning of their activities should remain their own responsibility or that of some intermediary body such as the Councils for Voluntary Service (C.V.S.) since they are unlikely to be suited to the more rigid planning which occurs in the statutory sector.

Further research into the suitability and effectiveness of voluntary services to client's needs is required since there is likelihood of altruism for its own sake. As with statutory services, information on their benefits, outputs and costs should also be applied. Finally, on a sceptical note, the underlying factors for emphasising greater voluntary participation in health care should be questioned, not only on the part of the policy maker, but also from the point of view of the volunteers themselves. We should be asking what motives they have for participating and who is the main benefactor in volunteer-client interactions.

4. CONCLUSIONS

From this selective review of the broad spectrum of research on community health services and community care policy, several research lacunae can be identified. The majority of the work on these services seems to be concerned with the elderly and it is for this group perhaps that there is greater concensus as to the desirability of community care. In the case of the mentally handicapped and mentally ill, there appears to be poorer development of community services despite frequent lip service paid to the establishment of Community Mental Health Teams and also a continuing debate as to whether mentally handicapped persons are able to manage in, for example, a group home situation and what their rights and permitted behaviour should be. Although the elderly are a more pressing concern for Health and Social Service planners and policy makers by virtue of their growing numbers, it is important that the ambiguity of the

status and treatment of people with psychiatric problems be investi-
gated and questions asked as to how society determines normative
levels below which people can be labelled mentally ill or mentally
deficient.

A further issue more directly related to the services (or
packages of services) themselves which has been identified by several
studies, particularly those concerned with modelling the structure of
and inter-relationships between Community Health Services is that of
benefit determination.

Acceptance of normative professional judgements is recognized as
giving a very partial view of the benefits actually experienced by
clients, but research in this area has not been forthcoming so that
this remains the main consideration of service benefits. What should
be developed is a "Benefit Indicator" which would combine information
on service outcome (real benefits) and ideas on perceptions of service
benefits by clients, their families and the professionals involved in
the allocation and delivery of care. Hitherto, these elements have
been dismissed as being too difficult or costly to measure, parti-
cularly since a general indicator could not be accurate over a range
of situations due to qualitative variations in services and individual
cognition . If services are to be treated as substitutes for one
another then their relative benefits must be considered.

Perhaps the most important areas for future research given only
general consideration, if any, in most of the studies discussed lies
in relating community care policy to wider political, economic and
social concepts. At a time when State provision of Health and Welfare
services is being curtailed we should be asking what is the role of
social services and how are they related to the State? Why are
particular policies applied as opposed to others and what is the
effect of their practical application to different sectors of the
population? We should also ask deeper questions about our society and
the mechanisms at work whereby individuals are labelled or classified
and whether the present systems of treatment are relevant solutions.
Socially derived phenomena also have a spatial expression and in the
context of public facility location are important considerations. For
example, the clustering or dispersal of family and kinship networks

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through time will affect the pool of potential informal carers; professionals in the health service have different locations and their spatial distribution and mobility may be a contributory factor in the reproduction of role and status definitions. These issues which question rather than accept or describe the existing system and the assumptions upon which social policy is founded are where more radical and relevant insights into the deficiencies, merits and possible improvements and direction of Community Health Services are to be found.

5. POLICY AND PRACTICE

The legislation and Government circulars and white papers which have variously defined community care policy have been discussed, together with a review of some of the literature on policy and services. The extent to which a policy is embodied in plans or is actually implemented can perhaps be considered as an indication of the degree of acceptance which it has in the minds of planners and practitioners at a local level and how practical or feasible they consider it. The correspondence of policy and practice then, will be examined briefly in order to try and assess whether references to community care have any significance on people's lives through its practical application.

Local authority Social Services Departments are responsible for part of Community Health Services and there is probably greater freedom and variation in the quality and quantity of services provided under their administration than in those community services provided by the Health Authorities due to their respective organization and power structures. Government guidelines have tended to be viewed by Local Authorities as distant targets to aim for or may not be taken seriously at all. Some research has suggested that it is the guidelines and recommendations which are inappropriate. This criticism has, for example, been directed toward service levels for the elderly. At present Government white papers recommend a certain number of places, hours of help, etc. per thousand population over 65. The elderly population is increasing both in absolute numbers and also as a percentage of the population, but it is the number of very

old people (over 75) which is showing the greatest increase. The central statistics office's "Social Trends" (1983) shows that the number of people in Britain aged 85 years and over has increased by 150% over the past 30 years and those aged between 75 and 84 have increased by 60%. It also forecasts that from 1981 to the end of the century those people aged 75 and over will increase in number by 13% whereas those in the 65-74 year old age group will decrease by about the same amount during that period. When one considers that it is precisely these "old elderly" who put the main demands on health and social services, then it might be more appropriate to revise the guidelines on facilities for the elderly in terms of the number of persons over 75. In other instances, Government policy has been criticized for being unnecessarily pessimistic. The white paper "Better Services for the Mentally Ill" (1975 Cmnd 6223) affirmed its commitment to community care as the main method of response to psychiatric illness but stated 25 years as its timescale for establishment of the new pattern of services. This suggests either that financial support for the policy is likely to be a uniting factor or that there is still uncertainly even at central Government level about the desirability of community-orientated health and social services for all sections of the population. Such uncertainty will probably be similarly identifiable in local practice and planning.

T A B L E 1

LEVELS OF SERVICE PROVISION 1975/76-1979/80 (ENGLAND AND WALES)

	0000s	Indices of Change					% Change 1979/80 on 1978/79
	1975/76	1975/76	1976/77	1977/78	1978/79	1979/80	
RESIDENTIAL CARE							
Elderly	120.3	100	104	105.5	104.8	104.1	(-0.7)
Children	37.3	100	100	97.3	91.7	90.5	(-1.2)
Mentally ill	3.6	100	116.6	127.7	127.7	135.3	(+7.6)
Mentally handicapped adults	9.1	100	112.1	124.2	128.6	138.5	(+9.9)
Mentally handicapped children	1.8	100	105.5	116.6	116.6	122.1	(+5.5)
Physically handicapped	6.0	100	110	115	121.7	123.6	(+1.9)
'COMMUNITY CARE'							
Home helps							
Number (WTE)	50.1	100	93.0	97.2	99.2	96.9	(-2.3)
Cases	670.5	100	102.9	107.8	109.2	113.6	(+4.4)
Hours service	80622.3	100	99.9	101.7	102.8	104.3	(+1.5)
Hours service per case	120.3	100	97.0	95.3	93.0	90.5	(-2.7)
Meals	41276.0	100	100.2	99.4	97.5	103.9	(+5.9)
Telephones							
No. of installations assisted	15.1	100	76.2	97.4	118.5	97.8	(-20.7)
No. of rentals assisted	70.0	100	105.1	118.0	122.6	137.7	(+15.1)
Aids	240.5	100	100.4	114.2	120.5	115.4	(-5.1)
Adaptations	50.3	100	108.3	114.7	135.2	114.1	(-21.1)
Holidays	101.2	100	86.2	85.3	88.6	89.3	(+0.7)
No.of sheltered housing units assisted	90.4	100	103.2	101	83.3	86.0	(+3.6)
Children boarded out	31.8	100	106.9	110.4	111.6	116.2	(+4.6)
Fieldwork staff	21.0	100	105.7	109.5	114.3	119.7	(+5.4)
Administration staff	17.2	100	109.3	114.5	109.3	107.2	(-2.1)

SOURCE: CIPFA, "Personal Social Services Statistics: Actual" 1975/76, 1976/77, 1978/79 and 1979/80

NOTE: Number of authorities covered (maximum 116): 1975/76 = 111; 1976/77 = 112; 1977/78 = 113; 1978/79 = 113; 1979/80 = 1

One method of examining trends in policy implementation is to examine the provision of units constituting community health services for different client groups. Table I shows the expansion and contraction of a range of services as compiled by the Chartered Institute of Public Finance and Accountancy (C.I.P.F.A. 1980). Yearly comparisons are cautioned due to slight variations in the number of local authorities completing statistical returns but they remain representative of broad trends. The table shows that for residential care, there has been a growth in provision for the mentally ill, mentally handicapped and physically handicapped but a reduction in the provision of residential care services for the elderly and for children. The expenditure on residential care in 1979/80 constituted the same proportion of the total as it did in 1978/79. These figures might suggest that firstly there has been no significant shift of resources from residential provision to community services, and secondly that the two trends in residential care services demonstrate the ambiguity of a community care policy which can be interpreted both as non-institutional in the case of the elderly and children and non-hospital for other client groups. However, there is a danger of invoking statistical inferences as explanation. The type of residential accommodation, for example, should be examined, also the relative proportions and increase in numbers of different client groups being catered for, and the extent to which greater provision of facilities for groups such as the mentally ill and handicapped is covering former shortfalls in allocated resources. Furthermore, it should be questioned to what extent the reduction of residential care resources for the elderly has been accompanied by improvements in domiciliary services. The Association of Directors of Social Services, reporting after their second survey on the effects of cuts or savings in expenditure on personal social services in 1980 painted a rather depressing picture. They found that:-

> "There was no evidence found of authorities
> explicitly closing residential facilities for
> the elderly in order to provide additional
> resources for community services."

However, even the diversion of resources at a local level could be considered contentious if such decisions are made without reference to developments in community health services provided by the Health Authorities. Also it may not be feasible to be withdrawing resources

from residential care at a time when the numbers of physically and mentally frail old people is increasing. Statistical tables of changes in the pattern of units of service provision are, therefore, limited in their description of policy implementation. Resource shifts must be viewed against a background knowledge of population changes, needs, and of developments in related services. In the case of home-helps, for instance, the demand for the service has increased dramatically in recent years. Table I suggests a 4.4% increae from 1978/79 to 1979/80. However, since the hours per case have declined, we can infer that the home-help service has responded to this greater demand by spreading scarce available help more thinly over a more dependent population.

It is hoped that a detailed study of the implementation of community care policy within Dewsbury District Health Authority which is in progress, will begin to answer some of these questions, and although much of the information will be specific to that area, that some more general points will emerge. For example, necessary and contingent relationships between services, informal care, personnel and clients can be ascertained which can be translated into other situations.

Policy is an exposition of intent (ends) and can also be a specification of active components which produce the desired intent (means). Throughout the development and successive definitions of community care, it has been cited as "beneficial" and assumed to be without explicit statements of why and how resources should be used. The administrative structure within which services are provided means that emphasis on budgets and resource inputs alone may ot be suffi-cient to secure community-based policy objectives. A comment made by Bosanquet (1978) in reference to the elderly can perhaps be taken as applicable to community health services for all client groups.

> "The elderly have been provided with a service which has been almost entirely set by society's view of what it thought it could afford rather than one fitted to the elderly's particular needs." In
>
> ------ "A truly preventative and community--based health service for the elderly remains a pious aspiration and a faint hope."

> (Bosanquet 1978)

Community care policy and its implementation so far are therefore suggested as arising from expedience rather than conscious, theoretically informed policy selection.

6. THEORETICAL DEVELOPMENT OF COMMUNITY HEALTH CARE POLICY

6.1. Introduction

The function of social theory is to explain observed phenomena. This statement, however, must be qualified by mentioning that conceptualization and observation methods are not theory neutral but theory laden. Central to any debate on social welfare issues are value and ethical judgements which become embedded in policy and practise and which are also at the root of any critique which might be offered. It must be stated then, that any attempt to describe or evaluate health and social services distribution or operation can only be given from an assumed theoritical or value base which cannot be designated right or better than other values which could be adopted. In connection with this point, there is a danger of reducing everything to the relative and taking the concept to mean that theory laden observation is theory determined and what exists cannot be truly known. Sayer (1981) provides us with some clarification by demonstrating that theory can be refuted from experience not just from its own terms and also mentions that although our observations and their fallibility can be accepted, it does not follow that all knowledge which proceeds from observation is equally fallible. What should be adhered to in social policy research is an explicit statement of the theoretical and ethical standpoint taken and consistent application of it throughout empirical research and descriptions.

6.2. Need

The concept of need is fundamental to an understanding of state welfare provision since it forms both a justification for provision and an objective to be met in more detailed policy.

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Health and Social Services are claimed to be allocated according to "need" and so the concept is also used as a rationing device. Despite its central position, there has been little theoretical development of the mechanism of need formation and thus of appropriate responses to needs. Several attempts have been made at classifying different types or levels of need. Bradshaw (1972) distinguished between normative need, felt need, expressed need and comparative needs. Jennifer Dale (1982) took a different approach by identifying three scales of investigation:

i) FINAL NEEDS — These are "ends" or goals to which other human acitivities are directed.

ii) INTERMEDIATE NEEDS — Here needs are viewed as a means of meeting ultimate or final needs.

iii) INDIVIDUAL NEEDS — These are the priorities attached to different individuals. These needs are rationing devices.

Social services tend to view needs as "intermediate" without explanation of the goals to be achieved. Intermediate needs can be considered as those which society has chosen to accept or recognize. Two opposing schools of throught criticize this emphasis on need. On the one hand, there are neo-classical economists who view demand as being a more appropriate mechanism for allocating resources (e.g. Culyer 1976); whilst there are also more "radical" theorists who include the spurious concept of need within a broader critique of capitalist society (e.g. Hirsch 1977). Three very different views of need then can be identified which indicates the variation of social policy analyses with different theoretical and value bases. In view of the established position of "need" in service provision, it should not be lightly dismissed as a very subjective and contentious concept. It would be useful, for example, to investigate whether there is any degree of consensus as to what constitutes a "need" and how society should respond in meeting these needs.

It is generally accepted that there are some basic needs, fundamental to human survival such as food, water, shelter, etc. which, unless satisfied, preclude any further human activity. This belief is reflected in the United Nations Declaration of Human Rights where, along with clauses relating to justice and civil rights, article 24 states:-

> "Everyone has a right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing, medical care and necessary social services."

Obviously, this is open to variable interpretation of the word "adequate". Also in some countries there may not be sufficient resources to meet these rights for every citizen. Nevertheless, they remain vital rights despite the fact that in some situations they might be thought more in terms of "final needs". To state basic needs as being rights, implies an obligation to meet them. This point will be returned to in more depth. So far, this view of basic needs reveals concensus only at a very general level. At a more detailed level divergence of opinion occurs.

The radical theorists view needs as being socially determined. Marx and Engels (1942) in "The German Ideology" wrote:

> "It is only biological needs which are taken as given. Consciousness of other needs develops with the development of society and forms of social organization, together with the state of technology, will condition the way needs emerge. People are not entirely imprisoned within the social structure, but these set definite limits to their actions."

Hirsch (1977) also emphasised the relationship of the individual within society in defining perceptions of needs and wants. If these wider needs are related to societal organization as he suggests, the class structure will influence people's relative needs. One of the defining principles of a social class is a system of moral concensus. A disproportionate amount of social needs relate to the lower social classes and where

their values differ very significantly from those of the dominant class which ascribes those needs, then there could be considerable divergence of opinion as to what consitutes a need and how obligations to meet them are viewed or accepted.

The pattern of values and perceptions characteristic of different social groups is by no means simple - either those in most need or those in policy formulation may have the wider view of what social action is needed by themselves or the whole of society. Those in greatest need may be least aware of their relative deprivation. If decisions about social policy and the underlying values are those of the upper and middle classes, then the objective of the welfare state meeting social needs will only be achieved in a distorted way such that, although overall standards improve, those in greatest need remain in a relatively deprived situation. In connection with this, it might be suggested that welfare provision and rationing may have aims which are additional (or alternative) to the aim of meeting needs. Welfare provision, for example, can be viewed as a means of social control and of the reproduction of social norms or as a means of labour selection.

Social policy is usually expressed as though it were the consensual view of society. The radical theorists consider that the nature of the power structure in society prevents the felt needs of the lower classes being considered in decision making - paternalistic attitudes amongst many professionals within the health service who consider the general public to be incapable of "knowing" what they need, is characteristic of this. An alternative explanation which develops this theme is that the structure of society moulds social and moral norms so that individuals may be unaware of their "real" needs and are, therefore, in a state of false consciousness. This view was stated by Marcuse (1956) who considered that false needs were super-imposed upon individuals by particular social interests which necessitated the repression of more instinctive feelings. This relates not only to the consumerism in capitalist society which depends upon perpetuating wants or needs in the population for goods which in turn is necessary for growth of the economy; but

the theory can also be seen in application to welfare provision
which is illustrated below in connection to community care.

Williams (1978) stated that:

"The word "need" ought to be banished from
discussion of public policy, partly because of
its ambiguity but also because the word is
frequently in in 'arbitrary' senses."

This statement well summarises the economists view of needs
or "needology" as Williams (1978) referred to it. Culyer (1976)
criticises the use of the need concept in social policy since
needs are usually stated in terms of people's need for services;
hence means are confused with ends and this can result in
continued, uncritical acceptance of existing forms of service.
This is probably one of the most valid criticisms of need as
used in present administrations.

Neo-classical economists addressing welfare issues do not
propose provision of health and social services by the private
sector and use of the market mechanism; welfare is viewed as an
exception to the norm of market regulation since it is a public
good which has externalities in terms of costs or benefits which
fall on those who are not participants in certain actions. The
wider influence of immunisation beyond the individual either
receiving or not receiving vaccination is an example of this.
The distribution of services in the view of this school of
thought should be according to demand and supply functions.
Demands are expressed through the political system and replace
needs as the rationing principle. The error here is the
assumption that demand is preferable in view of its greater
objectivity as compared to the highly subjective nature of
need. The social production of wants is, therefore, ignored.
Further, the satisfaction of consumer wants is not equivalent to
meeting need - a point which may not be crucial in consumer
goods but in health and social services could mean issues of
survival are at stake. However, at this stage the argument is
in danger of slipping towards a patronising view of a society
incapable of perceiving needs and articulating them.

We can conclude then, that needs are socially determined entities and as such are relative states which may or may not be recognized by different sectors of the population. Criticisms of "need" as an adequate basis for policy formation and service allocation are probably valid in view of the poverty of theoretical development. What should be introduced is the recognition of 3 scales of need and a thorough explanation of what final needs are being assumed. Within the contradictions of the present socio-political system and our inability to determine true and false needs this is likely to be only minor improvement to a system of informed decision making by professionals. Marcuse (1956), writing on this point, decided that the "true" needs of individuals could only be assessed when they had free choice in a non-oppressive society which he considered to be the true socialist state.

If we accept the existence of social needs beyond the basic qualities vital for survival, the response to those needs should also be considered. The fulfillment of needs can be seen either as a matter of obligation or as dependent on altruistic and benevolent feelings of an organization or individual. Obligation rests on the concepts of rights and justice, whereas the second response relates to notions of freedom of action. Titmuss (1970) in "The Gift Relationship" thought altruism to be an unlimited resource which thrives as it is increasingly depended upon. It has been stated that basic needs constitute rights and should, therefore, be met by individuals or by government institutions as the representative of society. State welfare provision in Britain, caters not for basic needs but for more developed conditions that relate to the development of society and technology. Since these needs have been created as a product of social organization it might be argued that there is an obligation for society to meet those needs. Titmus (1968) identified that the present system of social services represented:

"partial compensations for disservices, for socialcosts, and social insecurities which are the product of rapidly changing industrial urban society.

The extension of State services to care for dependent persons (previously the role of women in extended family networks) is, therefore, a consequence of urban industrialism changing the structure of the family and the role of women in society. It appears in the present community care policy that this is being regretted and women are being pushed back into the role of unpaid carers. If welfare issues are left entirely to altruism, there can be a problem of stigmatization of the recipients of benevolent action who do not like to be seen as dependent on the charity of others. Where issues of life and death are at stake, it must be asked whether it is morally acceptable to leave the meeting of need to matters of chance. The State, therefore, should take a leading role in social service provision. It would be unrealistic, however, to view this responsibility as infinite or divorced from issues of economics and available resource limits or standards of provision are once again relative to the moral and political stance taken. The present Government, for example, would view the role of the State in service provision at a more basic level than that which is operates now, preferring to cut back public expenditure and place the obligation for care back with the private sector or "the community". Some years earlier, Enoch Powell (1966) expressed the view that although new technological advances in the medical field now enable more lives to be saved and satisfy the need for survival, it did not mean that the State had a responsibility to provide that technology to all those whose lives could be saved by it. Needs, therefore, within the framework of State service provision have specific standards of satisfaction attached to them. More important than where these standards should be set and what the level of State intervention should be are notions of equity and the effect of policy on different sections of society. It is necessary, therefore, to try and determine the ultimate ends of services, their relation to final needs and whether the restriction of standards is descriminatory between certain groups.

6.3. "Community" ? and Community Care

In recent years, legislation and policy guidelines have been emphasising the community as being the appropriate location for certain client groups to be cared for. The changing definitions of policy from being non-hospital to care by the community itself, were discussed earlier. It is suggested that Government "community care" policy has been presented as a consensual view appealing to notions of the family and individual choice. Since the presence of a caring "community" is assumed, it is important to look at the validity of this concept.

George Hillery (1955), in his well-known study of communities found 94 definitions of "community" in the literature with the single common factor being their reference to people. Usually the term is used to describe a range of features of social life and their beneficial attributes. Marx held the belief that within capitalist societies, community was an illusory concept and that individuals trying to maximise their interests was a precluding factor. Freud, too was skeptical about the ideas of neighbourliness and friendship. In "Civilization and its Discontents" he described these values as introduced by the institutional elites of civilization in the interests of repressing human agression. In the area of social policy the myth of community could be seen as introduced by the State to justify limitations in public expenditure in contentious areas and as a means of social control of the labour market.

In terms of true and false needs, then, the need of individuals to remain in their own homes and be cared for by their familiar family and friends may be applicable to some people, yet for others family tensions or feelings of stigmatization from reliance on benevolent voluntary workers may be equally real. For some very isolated people or persons newly released from long stay mental hospitals, for example, "community" may be far more descriptive of friendship networks

developed in hospital or residential care institutions than in their experience of living a more independent existence. It is suggested then, that the blanket approach to community care is an inappropriate method for need satisfaction.

6.4 Conclusions

Since this paper has been prior to empirical research, the only conclusions which can be reached are in the form of hypotheses or suggestions for mechanisms which may underly the development of a Community Care Policy and it's implementation.

1) Community care has been described in emotive terms, disguising the reasons underlying its development. The economic, social and political factors in operation can only be identified through analysis of the system of community health services within a broader framework, e.g. Government policy and the social structure. The poor theoretical development of this policy and failure to make explicit the ultimate needs being pursued may, therefore, indicate hidden interests.

2) Community care is a system which denies costly medical care to the non-productive sectors of the population. This reinforces the primacy of production and economic growth which are essential to capitalism and the influence of the power and status heirarchy within the medical profession.

3) Community care is inequitable in terms of class and gender. The lower classes have fewer resources available to ensure an "acceptable" standard of living in retirement and also lack the same capacity to provide care for elderly or disabled relatives which can prove very costly. Financial resources in retirement do not only affect material and physical comfort — they can also affect a person's health — the example of hypothermia in elderly persons unable to pay high heating bills is particularly appropriate here.

4) Women bear the brunt of the responsibility for care in the community. The re-emphasis on care <u>by</u> the community (D.H.S.S. 1981) excludes women from the labour market and reinforces traditional notions of their role in society. It is also suggested that reducing the potential labour supply may also reduce embarrassingly high unemployment figures.

5) Community care has been introduced on the grounds of "choice" for the individual to remain in his familiar environment. In a situation when the alternative modes of care are being contracted or remain stagnant in the face of an increasingly dependent population, this "choice" may simply be Hobson's!

6) Deinstitutionalization of long-stay hospital patients without adequate back-up services and inter-agency collaboration may be replaced by a "psychological institution" in a society which cannot understand their problems and needs, or could result in a ghettoisation effect – islands of previously institutionalized persons living in group homes in a cosmetic attempt at rehabilitation and integration.

It is easy, however, to criticise social policy and services from a position of detachment on the basis of policy analysis and reports of single services. What is now needed is detailed exploration of the whole Community Care System in one or more areas, so that these concepts, their meaning and relevance can be thoroughly explored. From this general context of community care more specific aspects can then be studied.

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