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British Local Government's Role in Social Welfare

The Changing Relationships between Social Care, Social Assistance and Health Care

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<Abstract>

이 논문은 주요한 현대행정기능 중의 하나인 사회복지기능에 대한 지방정부의 역할을 영국적 시각에서 살펴 본 것이다. 특히 영국지방정부가 사회복지(소득보전제도: income maintenance, 보건:health, 사회보호:social care 포함) 기능과 관련하여 보여주었던 역할변화 및 이러한 역할을 수행하는데 수반되었던 조직변화를 검토하였다.

이 논문은 사회복지에 관한 지방정부의 역할을 검토하는데 있어서 역사적 접근방법을 이용하며, 그것이 어떻게 오늘날의 형태를 갖추게 되었는가를 살펴본다. 여기서 영국이라 함은 잉글랜드, 스코틀랜드 및 웨일즈를 포함하며 북아일랜드는 제외한다. 이 논문은 특히 영국사회의 많은 특징들을 두루 살펴 볼 것이며 사회복지기능과 관련하여 미래에 발생할 수 있는 주요 이슈들을 제시할 것이다. 특히 영국적 경험으로부터 다른 나라들이 교훈으로 얻을 수 있는 것들을 제시할 것이다.

I. Introduction

In this paper I will explore the role of British local government in relation to social welfare – defining that as concern with income maintenance (particularly social assistance), health and social care. I will look at the way the local government role has changed over time, in response to changes in its responsibilities and changes in its organization.

The field I have defined as “social welfare” above can be compared with a river originally flowing as one stream which has experienced efforts – of varying degrees of success – to divide it into three. The river flowed as one stream in the days when the only public agency with responsibility for social welfare was the “poor law”. From the beginning of the twentieth century onward the poor law was gradually replaced by other modes of public provision. Parts of its income maintenance and health care responsibilities were taken from it with the coming of a limited social insurance scheme in 1911. But when local government took over its remaining responsibilities under the 1929 Local Government Act it took on responsibilities in the realms of social assistance and health care as well as social care. Then, further changes in the 1940s largely reduced the local government role to social care together with some responsibilities for community health services. The latter were taken from it in 1971

In this way, as the one stream was divided into three, local government was left with responsibility for only one – social care. However, the three resulting streams have so much in common – there are so many areas of social life where policies from one stream have an impact upon or interact with the others – that the local government mandate is seldom clear cut and many crucial policy issues concern the relationship between the social care sector and either health or income maintenance, and sometimes both.

This paper will explore the local government role in social welfare by adopting an historical approach, exploring how it evolved to its present day form. It is hoped that this will help to make clear many of the peculiarities of the British system. It will also illuminate the point made in the last paragraph about the interactions between the sectors. It may also suggest issues that could or should emerge in the future. Hopefully also it will suggest lessons that other countries may learn from the difficulties Britain has faced in trying to work out the best way to relate these three streams to each other. In adopting an historical approach present day features and issues will not be neglected, the objective is to illuminate them.

Britain denotes England, Scotland and Wales. It does not include Northern Ireland where the history of local government has been rather different.

The account to follow will be divided into four sections:

Local government and social welfare between the Local Government Act of 1929 and the end of the restructuring of social policy in the 1940s in 1949
The period of growth and consolidation in which only marginal changes occurred to the system between 1949 and 1979
The period between 1979 and the present day
A concluding section which reviews where we are now and considers the issues for the future

II. Local Government and Social Welfare 1929 to 1949

Until 1929 local government's main responsibilities in the area of social welfare came from nineteenth century public health legislation which enabled authorities to take preventative responsibilities to deal with infectious diseases and to provide hospitals for the mentally ill. Early twentieth century legislation creating some community health services - community midwifery and health visiting in particular - added to the local services set up in the counties and county boroughs (also referred to below as the “higher-tier” local authorities) under the leadership of “medical officers of health” (Lewis, 1986).

The social welfare authority at the local level was not local government but the Poor Law Boards of Guardians. These elected bodies operated under central government supervision. Their social welfare responsibilities had developed as part of their responsibilities as the bodies required to provide maintenance to the poor. Nineteenth century legislation required them to maintain "workhouses". The aims of these were to curb indiscriminate "outdoor" relief (that is: outside institutions). If the poor were not sufficiently desperate to enter the workhouse they could not be really in need. The system was intended to ensure that those who received help were worse off ("less eligible") than the poorest people in work. In practice many poor law unions did not strictly enforce the workhouse test, and as the years passed the elderly and the sick were increasingly given outdoor relief. Interestingly however, the workhouses also developed an alternative function as hospitals for the sick poor and as care homes for elderly poor people unable to look after themselves and without families to do so. There were no domiciliary care services of the kind we have today, such activities were entirely left to the responsibility of families.

The income maintenance and health care responsibilities of the Poor Law had been affected by the introduction of social insurance in 1911, and the its consolidation in the 1920s, which aimed to enable modest income working people to obtain primary health care and income replacement when old, sick or temporarily unemployed without recourse to the means-tested Poor Law. We can thus, from this period in British history draw a distinction between income maintenance through social insurance for those with clear labour market attachments and the residual means-tested provision of social assistance (the Poor Law) for those not able to claim in that way.

The Local Government Act of 1929 handed over responsibility for the Poor Law from the Boards of Guardians to the local authorities. As far as the administration of relief was concerned this made little difference; the public assistance committees of the local authorities could be regarded as broadly the Guardians under another name. However, the handover of powers brought the institutions that had evolved from the old workhouses into the hands of authorities that could more effectively bring them up to date. This was particularly important for the hospitals, since now a unified public service could be provided. This was an important step towards a National Health Service, though in practice few authorities did much to modernize their facilities in the 1930s. Instead, the transformation of the hospital service awaited the special arrangements that were made to coordinate their activities with those of the voluntary hospitals during the Second World War (1939-45).

No sooner had local government taken over the cash assistance powers of the Poor Law than the government began to prepare legislation to take all means tested support for unemployed people under its own direct control. This was a period of high unemployment and there were wide divergences between local authorities in the provisions they were prepared to make for assistance to unemployed people. Central government regarded some local authorities, largely ones under strong Labour Party control, as too generous. Legislation passed in 1934 took all responsibility for relief for unemployed people away from local government and brought it under a national body, the Unemployment Assistance Board.

In 1940 the Unemployment Assistance Board was renamed the Assistance Board and took over from the local public assistance committees responsibility for means tested benefits for elderly people. This process of "nationalizing" poor relief was completed by the National Assistance Act of 1948 which added "National" to the name of the Assistance Board, and shifted all remaining powers to give cash grants to poor people away from local government. This nationalization or centralization of social assistance took the British system in a direction taken by few other countries. In most other European countries it remained a local responsibility.

But in taking away local government's cash giving powers the government had to decide what to do about responsibility for the institutions local authorities had inherited under the 1929 Act from the Poor Law. It decided that these should be the responsibility of the "higher-tier" local authorities - the counties and county boroughs. Part three of the 1948 National Assistance Act dealt with this issue, making these local authorities responsible for running care homes and also responsible for the supervision of voluntary and private homes (those there were very few of these at this time).

As Means and Smith (1985) show, the government's view of what it was doing here was the very limited one of placing the responsibility for residential care. The government saw itself as moving towards the replacement of the old residential institutions by modern residential homes for which people would get benefits towards the "rent" (plus pocket money). "Old folks hotels" the media christened them (Means &

Smith, 1985 : 152). There was very little consideration at this time of the development of domiciling services. The Ministry of Health failed to persuade the Treasury to allow local authorities a specific grant for this service, but after negotiation it did secure capital grants towards the development of new institutions.

The Poor Law had also involved some responsibilities for neglected orphans and other ill-treated children. The legislation, before 1945, on the care of children was muddled. It involved a mix of statutory and voluntary agencies. In 1945 there was a national scandal when evidence came to light that a child, Penis O'neill, had been killed by his foster father. An inquiry into his death (Monition Inquiry, 1945) found that the existing legislation did not define a clear division of responsibility between the education authorities and the residual local authority public assistance committees. As a response to this, the government set up a wider investigation into the services for deprived and neglected children (Curtis Committee, 1946). This recommended that there should be set up within each top-tier local authority a Children's Committee with its own chief officer and trained staff. It should be the duty of this committee and department to investigate cases of child neglect and to take formal steps to bring children in need of protection into the care of the local authority. The Children Act of 1948 enacted these recommendations.

In the Children Act the government placed central responsibility for children's services with the Home Office, the oldest and - at that time - most high prestige of the central government "interior" ministries. It has been suggested that it did this to try to ensure that this area of policy would get single minded attention. It might not have secured this within its obvious alternative bases at that time, the education and health departments. Certainly the Ministry of Health made a bid for it(Means & Smith, 1985 : 135). Hence a situation was created in which social care responsibilities were split at both local and central levels:

> care of children was brought under children departments in local government, supervised by the Home Office at the central level care of adults was brought under welfare departments (or sometimes - health and welfare departments, see further discussion below) albeit under the same local authorities at the local level,

supervised by the Department of Health at the central level.

But so far the discussion of the changes in the 1940s has left out health. The 1929 Act had, as has been shown, put some key elements of health policy – their longer standing public health duties and the former Poor Law hospitals – in local government hands. But many hospitals remained under voluntary control and publicly subsidies primary health care came under the social insurance system. When, therefore the Labour Government elected in 1945 decided to create an integrated publicly funded health service top-tier local authorities had clearly a good claim to be the appropriate authorities to run it at the local level.

This claim was rejected by the minister responsible for the health service legislation, Aneurin Befan. He resisted pressure from the strong local government interests within his own party led by a senior minister, Herbert Morrison who had been closely associated in the past with the government of London. Befan insisted that there must be direct central government control. He also argued that the small size of many local authorities would make necessary the adoption of “joint boards” which would not work very well and that his reform could not await the restructuring of local government.

Under the National Health Act of 1946, however, the higher-tier local authorities were left with responsibility for community health services – community nursing and health visiting, school health services and a general range of duties in respect of the protection of the public from environmental hazards. Local authorities were also given opportunities to be represented within the governing bodies set up for the National Health Service.

III. Growth and Consolidation 1949 to 1979

The last section has shown how, after a rather muddled period between 1929 and 1945, legislation between 1946 and 1948 seemed to set the “banks” for the three social welfare streams: social assistance under central control linked with other national income maintenance policy, health care under a national health service with local management arrangements which provided for no more than consultation with local government and social care under local government.

But even then the position was not quite a simple as that. The fact that local authorities were to run the homes for poor people in need of residential care meant that arrangements to assess charges for that care had to be co-ordinated with the central social assistance agency, the National Assistance Board. Also important was the fact that the community health services had been kept with local government. But most important of all the social care responsibilities of local government had been split between children′ and welfare services. Furthermore some local authorities recognised the connection between community health services and social care services and created unified “health and welfare” departments under Medical Officers of Health rather than letting these two sub-streams run their separate ways.

Between 1949 and 1979 the most important developments involved the growth of the various social care services in importance and in sophistication. The 1946 Children Act, with its demand for trained specialist staff, played an important role in the development of a new public service profession - social work. Packman (1975) has shown how the staff of the Children′s Departments soon became important initiators of new approaches to their task, stressing the need for “preventative” work alongside their powers to take children into care.

There was a contrast at the local level between a rather muddled package of general community health and welfare measures and the new departments set up with a clear “mission” under the Children Act. Griffith (1966) has shown how this difference was reinforced by the much clearer central inspection system set up for the latter, pushing standards forward and guaranteeing a dialogue between local and central government. The final advantage for the children′s service was that responsibility for it was placed in a high prestige ministry (the Home Office) rather than in the Department of Health.

Yet the health and welfare departments of local authorities also began to evolve domiciling services to supplement the institutional care they provided. Initially, it was the health service legislation that allowed for the development of a range of domiciling care services. It is interesting to note here how home help services established under this legislation, principally to meet the needs of new mothers in an era when home births were the norm, subsequently became a key element in the provision of home care for elderly people.

By the early 1960 the growth in the work of local government in relation to social care, but also in many areas in addition to those which we are concerned here (such as education and housing) led to agitation for structural reform. In 1963 changes were made to the system of government for Greater London. But it was the arrival of a new Labour Government in 1964 which really began what Klein – referring specifically to concerns about control over the National Health Service, but his remark applies as much to local government – called the search for "an organizational fix" (Klein, 1989 : 90).

Separate Royal Commissions were set up to examine the structure of local government in England and in Scotland (HMSO, 1969a and 1969b). Committees of inquiry were asked to make recommendations for the restructuring of the social care services (with again separate ones for England and Wales on the one hand and Scotland on the other). Consultative documents were published floating ideas for changes in the structure of the National Health Service.

The change process was slow, efforts were being made to relate the changes to each other. The most major changes were in the structure of local government, but are not particularly important for this paper. They gave social care responsibilities to new large top-tier authorities in Scotland, whilst in England and Wales little changed in the rural areas but in the major urban conurbations a system of over-arching counties comprising large urban districts was set up with social care responsibilities given to the districts.

Most important for this account is the changes made to social care arrangements in local government. It is fair to say that at that time the reform of the personal social services was a matter in which the party politicians were not particularly interested. Reform came about as a result of determined lobbying by a small group of social workers and academics. This story, as far as it affects England and Wales has been carefully studied by Phoebe Hall (1976). She shows how a small group, with some links with the Labour Party leaders, reacted against an initial set of ideas for a family service and exploited the concern for new community initiatives to deal with delinquency (see the report of the Ingleby Committee, 1960) to secure the setting up of the Seebohm Committee in 1965 “to review the organisation and responsibilities of the local authority personal social services in England and Wales and to consider what changes are desirable to secure an effective family service” (Seebohm Report, Cmnd. 3703, 1968 : 11). An advisory committee was also set up in 1965 by the Scottish Office to make recommendations for that country.

The Seebohm Committee recommended the setting up of unified local authority social services departments, bringing together the former children′s and welfare departments. It considered that the existing local authority health services for mentally ill and handicapped people should come into these new departments, as should educational welfare services. The report had an unfavourable reception. Hall, relying on evidence from the published diaries of the responsible minister (Crossman, 1977), reports that the initial reception by the Cabinet was hostile. However, it did not reject the report out of hand but rather referred it to a subcommittee. The medical pressure groups were also hostile to the report. The reaction of the local authority associations was ambivalent, they were “reluctant to react... before the publication of the Royal Commission on Local Government” (Hall, 1976 : 87).

Yet the Seebohm proposals were enacted almost in their entirety (except for some blurring of the takeover of services from education) in 1970. Why did this happen? In essence Hall′s conclusion is that the case for the Seebohm Report was advocated effectively by a small group of social work activists operating as “a coherent political force for the first time” (Hall, 1976 : 108). By contrast the medical profession was very preoccupied with the health service changes, the main medical group threatened - the local authority Medical Officers of Health - being particularly affected by those. Hall suggests that the responsible minister was similarly preoccupied by the health reforms and really rather indifferent to issues about the personal social services.

The Scottish changes were enacted even more quickly, in 1968, the year in which the Seebohm Report was first published. These were more radical than those eventually enacted in England and Wales since the Scottish equivalents of social services departments, called “social work departments” were given more comprehensive welfare responsibilities. They took on responsibilities for the supervision and after care of offenders, a duty that has remained in England and Wales largely with the "probation service" under the supervision of the Home Office and the courts rather than under local government.

Reference has been made, in the discussion of the Seebohm recommendations, to the unsuccessful bid by the local authority Medical Officers of Health to run unified community health and welfare services. In fact, the health service changes which were eventually enacted moved the community health work, which had been kept in local government when the National Health Service was set up, into the health service.

The Royal Commission on Local Government in England (HMSO, 1969) revived the debate about the health service which Herbert Morrison had lost in the 1940s. It proposed that health should come under local government control. The second health services consultative "green paper" rejected this proposal, setting out two reasons (HMSO, 1970). The second of these made little sense at a time when the whole system of local government was under review. It was argued that "the independent financial resources available to local government are not sufficient to enable them to take over responsibility for the whole health service" (HMSO, 1970 : 7). It was thus surely the first reason that was crucial: "the professions believe that only a service administered by special bodies on which the professions are represented can provide a proper assurance of clinical freedom" (HMSO, 1970). What was proposed instead was the move of community services into the National Health Service, together with a compromise in which both the professions and local government were each to be given a third of the places on the governing bodies, with the other third being appointed by the Secretary of State.

The reform of the structure of local government and of the health service was not carried out within the lifetime of the Labour Government (1964-70), but was enacted - in a somewhat different form by the incoming Conservatives (again the details are not relevant here). But, as indicated above, the personal social services reorganisation legislation had already been enacted. This was thus inevitably rather out of line both with reform of the local government system, within which it was embedded, and with reform of the health service, to which it has to relate closely. The former disjunction was particularly significant in getting the new social services departments off to a bad start, because in many areas outside London they had only just been established when local government restructuring required drastic changes. The issue about the relationship between this change and the health service change is more complex. Certainly the social services reform took some tasks away from local authority health departments just before their absorption into area health authorities. However, what now seems more important, viewing this reform retrospectively, is that decisions were taken very quickly in 1969 and 1970 about the split between the two services, especially in areas like the community care of mentally ill or handicapped people. As a consequence overall boundary problems between the two services continued to give rise to difficulties.

The integration of the social care responsibilities of local authorities has been noted as a response to their growing importance. Once integrated in the 1970s they grew even more rapidly. The new local authority social services, or (in Scotland) social work, departments were able to grow into powerful new forces in local government, second in size only to education departments. Their social problem focus and their responsibilities for services to a growing group in the population - elderly people - gave them an increasing importance. They secured a place for themselves in the expenditure patterns of local government that they had some success in sustaining even when local government finance came under strain in the late 1970s and early 1980s (see Webb and Wistow, 1982 and 1986).

To summarise the main ingredients of the story up to 1979 it is appropriate to revert again to the stream analogy. On the face of it the changes of the late sixties and early seventies reinforced the banks of the three main streams - shifting the anomalous element of health services delivery (community services) into the mainstream of the National Health Service. But there are two reasons for doubting whether the three streams had been so clearly separated. One of these is particularly important: the growing evidence that it is not simple to draw a clear distinction between health and social care. The other is less important but nevertheless interesting: that there were difficulties in drawing clear-cut distinctions between issues about service delivery and issues about income maintenance in a country where social assistance was growing in importance again (despite the Beveridge Report's aim to make social insurance the main vehicle for income maintenance in Britain). These two issues will now be examined.

There are many respects in which the concerns of the health service and those of the social services departments overlap. The following are a few key examples. In the planning of services attention has been given to the way in which people are likely to require mixtures of health care and social care. In this example what is particularly relevant is the modern concern to maximize care within the community rather than inside institutions. What this implies is a combination of medical care from general practitioners and community-based nursing staff, on the one hand, and social care, from home helps, social workers and so on, on the other. Deficiencies on either side may have to be made up by extra services on the other. Both are in many respects supplementing the care responsibilities assumed by families.

The discharge of patients from hospital in itself has substantial implications for personal social services provision. It is important that social support services are readily available at this stage. Hence day-to-day coordination between the two services is crucial. Discharge of people from geriatric wards will have implications for residential homes. Conversely, when old people's homes can no longer cope with their sickest inhabitants intensive nursing services need to be readily accessible.

Mental health services began to shift in the 1970s away from care in hospital to care in the community. Such care may be carried out either by doctors and community nurses, employed by the health service, or by social workers, employed by local government, or by some combination of the two. There is a need for local agreements about areas of responsibility and local arrangements for collaboration. Social workers have a special role to play, originating from one of the responsibilities of the Poor Law's "relieving officers" and codified in the Mental Health Act of 1959 (and even more so in a further Act of 1983 - but that is to advance into the next period in this account), to take action in mental health emergencies, when people are harming themselves or others.

A very different example of the need for interservice coordination and cooperation is supplied by the problem of child abuse. Nonaccidental injury to children is frequently discovered by doctors and health visitors, working in the health service, yet it is the social services departments that have the responsibility for preventative and legal action in these circumstances. On the other hand, where social workers suspect child abuse they may need medical confirmation of their suspicions. Once child abuse is suspected continued vigilance is necessary. Sometimes it is a health service worker who is best placed to maintain a watching brief, sometimes it is a social worker. In many cases both departments accumulate evidence on this problem; it is important that they share that evidence both formally through case conferences and informally (Hallett and Stevenson, 1979).

These are just a few examples of situations in which the relationship between the two services is significant. Many other could be given, both where joint planning of services is important and where joint action and cross referral is required. Their importance led the Department of Health in the 1970s to encourage, and the local agencies to adopt, a variety of means of developing links.

At the service planning level the Department of Health led the way by emphasizing the need to look at the health service and personal social services together (Department of Health, 1976 and 1977). Within individual localities they encouraged the development of formal joint planning activities. A particular stimulus to this has been provided by “joint financing”. Money from within the health service budget was made available to help to finance projects within the social services departments that could be considered to meet needs that might otherwise have to be met by the health service. In the long run social services departments were expected to take over the full cost of these ventures.

The more the emphasis on community as opposed to institutional care (and this was to become increasingly the case in the period after 1979) the more complex became the relationship between the role of the National Health Service and the role of the local government managed social care services.

Turning now to the social care/social assistance boundary it is important, first of all to recap on the political commitment, in the 1940s, to separating income maintenance from the personal social services. This was influenced by popular hatred of old Poor

Law. It was seen as possible to develop services for all freed from the stigma of the means test and the workhouse because the National Assistance Act of 1948 gave all income maintenance responsibilities to a national body and the duty to provide residential and domiciliary care to the local authorities. The services for children were given a quite distinct identity by the Children Act of 1948, and developed their own special approach to community care within the children's departments of the local authorities. A concept of social work was able to develop, very different from that within the American welfare departments where income maintenance and social work are closely linked(Stevenson, 1973). Social workers, regardless of their political persuasion, came to see it as very important that they were able to give aid, advice and support to their clients without at the same time having responsibility for their incomes. What this implied was that, whereas personal social services under the poor law were essentially for the poor, and were very involved in the control of the lives of the poor, it was possible to conceive of the benefits of the services as available to all without discrimination.

That, then, was the ideal; the reality was - and still is - a little different (Jordan, 1974; Hill and Laing, 1979). It is clearly the case that a very high proportion of the users of the personal social services are low-income people. It is quite hard to envisage a situation in which it could be otherwise. The peculiarity of the personal social services is that they are concerned with a range of benefits that is also provided in other very different ways, by both commercial enterprises and voluntary activities. The very existence of a statutory group of services of this kind poses some delicate questions about the nature of the balance between this and individual, family and community, provisions. The assumption is that the statutory provisions are necessary when the others fail. Politicians get worried about the possibility that private responsibilities will be abandoned in favour of public ones. This is possible; it is in the nature of statutory intervention into areas generally the realm of private action that it may alter behaviour. However, the evidence is that typically those who seek help from the personal social services do so when other possibilities no longer exist. An absence of other ways of meeting such needs is particularly associated with poverty.

Several connections between income maintenance and the personal social services therefore exist. Many of the services are rationed by means of charges, motivated at least partially by that political concern to keep down the expected volume of demands upon the service. If charges are not to deter service use by the poor, therefore, they must be abated through means tests. These need to be related to the other means tests within the social security system. That is one connection; the other is more complicated and more clearly explains the social work concern about separation of their services from income maintenance. There is a correlation between the forms of pathology that come to the attention of social workers delinquency, child abuse, even publicly threatening mental illness and poverty (Holman, 1978). It is difficult to summarize here a very complex, and deeply value-laden, debate. Strands within it include arguments about the extent to which the rich can hide their pathology, or seek help from sources other than social services departments; about the extent to which poverty causes social pathology and vice versa; and about the extent to which this "deviancy" simply involves a labelling of the non-conformity of the poor. The fact is however that it is primarily low-income people who become the clients of publicly employed social workers.

It is this fact that leads many who have written about social work to stress the importance of a relationship with the poor that does not include responsibility for their incomes (Jordan, 1974). Yet at the same time many social workers recognize a need to help clients with their income maintenance problems. There was a power given by the 1963 Children and Young Persons Act in England and Wales (now in the 1989 Children Act) and - rather more emphatically by the Social Work (Scotland) Act 1968), enabling money payments to be made to help social services clients where these might assist in keeping children out of care. Here, then, was a statutory recognition of a connection between lack of money and social pathology. Yet these powers have been comparatively little used, and several writers have drawn attention to the danger that they might be used to reward good behaviour and become a social control device within social work (Jordan, 1974 ; Handler, 1973). In general, an alternative approach has been referred in which social workers assist clients to claim benefits from other agencies. Such work is generally described as “welfare rights work”. To some degree, in many authorities, specialist workers, who are often not social workers were taken on to do this sort of work. However, social workers are bound to have to take on some of this work, some do with great commitment while others feel it will distort their activities and pull them away from “real” social work.

In sum, then, whilst the social care/social assistance divide was fairly clear in the period under review (and has remained so), three considerations prevented that division from being as absolute as it might be in theory. These were:

> the fact that most social care clients are poor, and likely to need social assistance
> the fact that charges for social care services had to be related to social assistance provisions
> the fact that social care agencies were, during the 1960s, given limited powers to make small grants and loans to clients

In the next section it will be seen that just as community care increased the need for interactions between social care and health care services so changes to both social assistance and community care increased the importance of some transactions across the social care/ social assistance boundary.

IV. Another Period of Change 1979 to 1996

The last section has shown that by 1979 the three services – social care, social assistance and health care – flowed within very largely separate streams, yet there remained difficulties about that separation and, as far as community care was concerned there was anxiety that the separation had gone too far.

In 1979 the Conservatives regained power under Margaret Thatcher's “new right” leadership. They remain in power at the time of writing, now under the leadership of John Major, but will face a General Election, which it is widely predicted they will lose, in the spring of 1997. As far as the concerns of this paper are concerned there are three general points to be emphasised about this long period of Conservative rule:

> one has been their general concern to curb social policy costs, which has inevitably meant an increased emphasis upon care outside expensive institutions (particularly hospitals) - an emphasis that can obviously be justified in terms other than simply the saving of public money
>
> another has been a distrust of local authorities as policy actors, a perspective that again may have some more general justification but that has been particularly fuelled by a tendency of the major urban authorities to be Labour controlled and for some of them to have seen opposition to 'Thatcherism' as a crucial mission
>
> related to these two has been a strong interest in institutional change designed to increase the range of service providers in society, and particularly to increase the role played by both private "for profit" organisations and by voluntary organisations.

The early 1980s saw only gradual change to social policy, then in the second half of the decade there was an explosion of innovatory legislation. The key Act as far as this article is concerned was the Health Services and Community Care Act of 1990. Much of this discussion will deal with this, starting with the community care part. This is the most important part for the local authority role. To explain this legislation it is important to go back to events early in the 1980s which contributed to a need for legislative change.

We have seen that, since the 1929 Local Government Act local authorities have been responsible for residential care for the elderly and handicapped who are unable to survive in their own homes. But the 1948 National Assistance Act, coming as it did alongside the setting up of the National Health Service, did not maintain a duty to provide nursing home care within the local authority responsibility. A distinction was made between social care as a local authority responsibility and a nursing care in an institutional context which was seen as a health service responsibility. Of course, this was a difficult distinction in practice since most of the people who went into social care homes were already very frail and it was often difficult to determine how and under what circumstances they might then be transferred on to National Health Service hospital care.

In the period before the 1970s the numbers of elderly, and particularly of very old elderly, were relatively low. Most families strove to cope with care problems in their own homes, and in particular people were very reluctant to use local authority institutional care unless they really had no alternative. The quality of much of this care was slow to rise above the standards of the old "Poor Law" institutions and some of the stigma of the Poor Law remained (Townsend, 1962). From the 1970s the numbers of the elderly in need of institutional care began to rise, and with that rise came the use of a variety of private homes by those amongst the elderly who could afford to pay for it (or whose relatives could afford to pay).

The emergence of private care homes obviously reduced the burden upon statutory care providers. They made it easier for local authorities to maintain an adequate supply of residential places. Before 1980 the central social assistance authority was, in general, unwilling to help low-income people in such homes. Then the rules were relaxed and local social security office managers were given considerable discretion to subsidize charges through means-tested benefit payments. The Conservative Secretary of State was placed in a dilemma between his commitment to the development of the private sector and his concern to keep income maintenance expenditure under control. Then, in 1983, he imposed national limits. These were nevertheless much higher than had prevailed before 1980 when commercial home charges were rarely met. There followed a dramatic growth of private sector homes. What is more that growth extended to nursing homes, doing very much what had hitherto been considered to be the work of the National Health Service and charging higher fees than care homes. A special high social assistance rate was allowed for these.

A report on community care by the "watchdog" body set up by the government to undertake monitoring and "value for money" studies on local expenditure - the Audit Commission - talked of the "perverse effects of social security policies" in these areas of private care. It pointed out that anyone entitled to means-tested benefit "who chose to live in a residential home is entitled to allowances" up to the limit imposed by the benefit rules. It went on:

> In short, the more residential the care, the easier it is to obtain benefits, and the greater the size of payment. And Supplementary Benefit funding cannot be targeted towards those individuals most

> in need of residential care. Nor are homes judged on whether they are giving value for money within the category of care for which they are registered (Audit Commission, 1986 : 44).

The Audit Commission team was very concerned about the extent to which this income maintenance subsidy of residential care distorted the pattern of care in the country as a whole. It noted the extent to which private homes were unevenly distributed geographically, commenting on their high incidence in the relatively prosperous southern and south-western parts of England. The consequences of this was, it said, that "while central government attempts to achieve equitable distribution of public funds across the country, through the use of complex formulae within the National Health Service and local government, the effects can be largely offset by Supplementary Benefit payments for board and lodging" (Audit Commission, 1986 : 3).

After the Audit Commission report on community care, the government commissioned Sir Roy Griffiths to make recommendations on community care policies as a whole (Griffiths, 1988). Griffiths suggested that there should be a system under which local authority social services departments decided on social, not income, grounds that care was necessary and then had a responsibility to ensure that individuals obtained that care, either from the public or private sector. If individuals were unable to pay the care costs from the standard social security benefits or from other income, it would then be the responsibility of the local authority to provide a subsidy.

The government accepted these recommendations and embodied them in the 1990 Act. In doing so it also incorporated a move towards the partial privatisation of all existing local authority services in the area of community care. It aimed to ensure that the relative role of local authorities as the direct providers of care (both in residential homes and community services) would decline in favour of the private sector. Local authorities were to become the "buyers" of packages of private care for low income people, while their role, as suppliers, of such care declined. There was a great deal of talk about the need for a "level playing field" on which existing private homes and new private providers of domiciliary care could compete with existing local authority providers.

This transfer of responsibility was complicated. It involved mechanisms to shift resources from the social security budget to the local authority social services budget.

These were the subject of complex negotiations between central and local government. The latter certainly felt that it acquired insufficient new resources for the job.

Since the full implementation of the 1990 Act in 1993 individuals in need of social care apply to their local authority. Officials of that authority are required to go through the following decision process:

> does the individual need social care?
>
> it "yes", what package of care is appropriate, bearing in mind the need to try to keep the individual in their own home and to minimise cost?
>
> having determined the appropriate "care package" they must put it together from either their own resources or services that can be purchased from private sector or voluntary agency providers
>
> to assess the contribution the individual should make to the payment of the costs of their own care - in other words the application of one or more means-test

Naturally that it a rather abstract model of what is supposed to happen. In reality the stages may be mixed together, and there are good grounds for the suspicion that the initial determination of need is influenced by what is available and what either the local authority or the individual (as appropriate) is able to afford.

A crucial aspect of this new approach is the idea that the local authority is to be the commissioner or purchaser of care for the individual but not necessarily the provider. The government has been very keen to ensure that alternative providers are drawn into the social care business. Hence many authorities would argue that the "level playing field" referred to above is not level at all, but has a distinctly biased "slope" towards alternative providers. Indeed at the time of writing the Secretary of State for Health, the responsible central government minister, has indicated a wish to shift the system so that eventually local authorities are limited to a "purchasing" role and cease to be providers at all.

This community care legislation applies to adult services. Whilst in 1989 there was a Children Act, which consolidated child care legislation, it did not significantly alter the local authority role with regard to the protection of children from abuse and neglect. However, the very fact that the child care responsibilities of local authorities remain unchanged except for efforts to codify and clarify them, whilst adult services are going through a quite revolutionary change does begin to call into question the idea of the integrated social services department embodied in the legislation of the 1960s. Could it be that we are in due course going to see again the splitting off of children′s services? This is a theme to which we will return.

Having outlined the impact of the 1990 Act on the local authority social care role there is a need finally to turn to relevant developments in the other two streams which remain outside local government.

Earlier comments have indicated how extensively social care and health care responsibilities interact. The 1990 Health Service and Community Care Act imposed a rather similar purchaser/provider split on the health service, but without nearly so strong an emphasis on alterative private or voluntary sector providers. We do not here need to go into the detail of this part of the legislation. But there are some specific aspects of it that need mention.

First, it may be seen as imposing tighter forms of budgetary control over the health service as a whole. One of the main implications of these controls is that they have increased the propensity of health authorities to try to pass on responsibilities at the margin. One particularly important “margin” concerns the long-term care of people who are in need of intensive nursing services but for whom active medical intervention can achieve little. People with mental illnesses and learning disabilities are within this group, but the people most affected by this are the severely handicapped elderly. The fact that social services departments may purchase nursing home places for such people offers the excuse for this shift of policy. But whilst National Health Service beds are free to all deemed to be in need of them places in private or voluntary sector nursing homes have to be paid for. Local authorities are expected to apply means-tests so that residents pay as large a proportion of these charges as they are able to. Hence, on this health care/social care border there has been a significant British retreat from the principle of free health care.

Other aspects of the 1990 Act may help to resolve some of the “who does what” questions at the health care/social care boundary more satisfactorily. Certainly the case for inter-authority collaboration between health and personal social services continues to be strongly influenced by government. But there is one other aspect of the 1990 Act that may work against that ideal - and which certainly raises questions for the future - that is that it ended local authority representation on health authorities of all kinds.

Finally in this section let us return to the social care/social assistance boundary. In the last section it was shown how concerns about the resources of social services clients led to the development of what is described as “welfare right work”. During the 1980s and 1990s the character of welfare right work changed as the social security system changed. Before 1980 the concern was to get social assistance officers to exercise their extensive discretionary powers. After 1980 the complex structure of apparent “rights” in new social assistance legislation required that poor people secured help in finding their way through the regulations, identifying things to which they were entitled and getting the increasingly hardpressed social security administration to grind into action. Further social security changes brought in by the 1986 Act threw the social workers and welfare rights specialists into turmoil. Rights to single payments more or less disappeared. Instead restricted discretionary payments were available in exceptional circumstances, but generally only as loans. This new “social fund” scheme seemed to require social services personnel to replace the conflictual pattern of behaviour required to secure rights by collaboration with social security officers to determine needs for help. The loans rules suggested a need for a very different approach to getting resources for clients, since successful “advocacy” might bring with it heavy indebtedness to the system. The position was further complicated by the fact that social services departments retain their power to make grants described above. In practice this power is little used, and most departmental budgets for this item are limited. If this were to change, or if social workers are coopted into helping determine needs for “social fund” grants and loans, social workers could be back to money rationing responsibilities in a big way. This development was feared when the “social fund” was introduced, in practice social workers seem to have coped with the conflict, very often by turning a deaf ear to material needs.

The complicated system of benefits for disabled people, which may interact in complicated ways with provisions for institutional care and the provision of caring services also poses a number of problems for social services clients where welfare rights advice can be invaluable (see Fimister, 1995). Beyond these there are questions to be addressed about the means-tests used for the services social services departments subsidise under the 1990 Act, and about their compatibility with other social assistance rules. The social care/ social assistance boundary remains a complex one in many individual cases (see Fimister, 1995). All this is complicated also by the benefits available to help people pay rents for housing. These are the responsibility of the social security ministry at national level but are administered by another part of local government. I have left this issue out of the discussion in order not to complicate it unduly (it is well described in Fimister, 1995).

V. Conclusions

This paper has used the analogy of three streams, created from a single one running close together and mixing in various ways, to describe social care, health and social assistance in Britain. Only the social care stream has been the distinctive responsibility of local government since the 1929 Local Government Act, and it has increased considerably in importance for society over the past seventy years. The legislation of the 1940s broadly established the contemporary divisions of the three streams: between local government, the health service and the centrally controlled social security system. Organisational changes around the end of the 1960s and the beginning of the 1970s took the last elements of health services - community services - away from local government but at the same time the claim of community physicians that they should be responsible for social care was rejected.

Despite what now seems to be fairly clear structural divisions between the streams there are a variety of ways in which developments in one stream impact upon policies in another, and the specific needs of individual people make it important that there is collaboration and co-ordination between the different services. It has been shown that the growth in the importance of community care has reinforced the need to come to terms with interactions between the three policy areas. In particular it has been suggested that the complexity of the boundary between health care and social care leads to a danger that a gap will emerge between services, or even that one service will try to push costly responsibilities onto the other. A further difficulty with this boundary is that, in practice, much social care in not regarded as a state concern at all but a responsibility of the family; hence a widening gap between services increases pressures upon hard pressed relatives who need back up from publicly funded caring services. It has become fashionable in Britain to talk about a "mixed economy of welfare" - involving contributions from the family, the voluntary sector and the private purchase of services alongside the state (Webb, 1985). In principle it is not unreasonable to expect that, in a context of shortage of publicly funded resources, there will be a complex combination of this kind. But if this is the case it is important that, if hardship to individuals is to be avoided, gaps in publicly funded services should be explicitly identified, acknowledged and justified. They should not arise unpredictably and perhaps by accident just because two services are poorly co-ordinated or because one service is trying to shift its burden to another.

Hence, ambiguity about the boundaries between streams and a lack of co-ordination across those boundaries remains a matter of concern in Britain. This is particularly true of the social care/health boundary, less true of the boundaries between those systems and social assistance. The question that is regularly asked about boundary problems is: can they be managed by liaison devices, joint working arrangements and so on, or would their joint management in a single service be better?

The fact that, in each of the countries which make up Britain, health and social care are under a single ministry at central government level (the Department of Health in England, the Welsh Office in Wales and the Home and Health Department of the Scottish Office in Scotland) obviously leads people to debate from time to time whether they should remain institutionally separated at the local level. Logically there are two options for this: the bringing of health care under local government and the bringing of social care under the health service.

It has been shown that, at various points in its history, local government has advanced a claim to run the health service. There is clearly a case for establishing some form of democratic local control over health delivery. The medical profession has always been a vehement opponent of this idea. Since there is now – for the health service – a split between the purchasing function and provision there is a case for reopening the argument. If local authorities became the purchasers they would not be the employers of the clinicians, who work as – or for – the providers.

However, it is the other option – the shift of social care into the health service which is more likely to secure political and pressure group support. In this case, the way in which adult care provision has began – since the 1990 Health Services and Community Care Act – to evolve away, as was pointed out earlier, from the children's service with which it was united at the end of the 1960s prompts the suggestion that a redivision of social services and social work departments may occur at some time. If that happened then the case for moving community care in with health care might become very strong indeed.

What I have had to say in the last two paragraphs is speculative, it is not confident prediction. Nor would I wish anything I have had to say there to be regarded as recommendations. These are merely reflections on the peculiar history of three streams that keep flowing closely together and whose dividing banks have been breached and repaired from time to time. Their closeness as activities made these developments likely, it seems improbable that there will not in future be further shifts in the way the streams flow. How significant those shifts will be will depend upon other kinds of institutional reform – probably badly needed in Britain – in the roles of national, regional and local governments. But to launch onto that topic would need another paper.

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