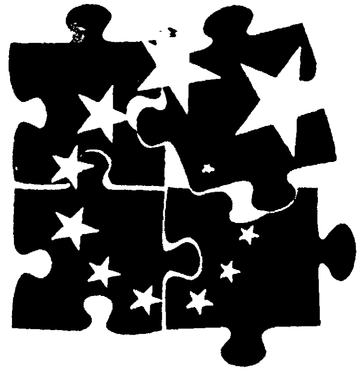

SOCIAL SERVICES AND SOCIAL EXCLUSION

REPORT OF THE EUROPEAN COMMUNITY OBSERVATORY ON NATIONAL POLICIES TO COMBAT SOCIAL EXCLUSION

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SOCIAL SERVICES AND SOCIAL EXCLUSION

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This report was produced by independent experts,
and should not be taken to represent the views
of the European Commission

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Except where otherwise stated, the Tables are based upon information provided by the national experts of the Observatory.

FOREWORD

The family and the local community are often seen as the archetypes of social protection. Where they fail to function effectively, their members are liable to suffer. This is especially likely at certain critical stages of the life cycle - birth, sickness, disability, old age, unemployment.

The social services (sometimes known as the "personal" social services) are here taken 5s those which aim to support the family and the local community as systems of social protection. These services are central to some of the major policy developments relevant to social exclusion that are currently under way in the member states of the European Community (EC). In Spain, for example, the resurgence of Non-Governmental Organisations (NGOs) in the social welfare field has included the development of home help services at municipal level. In Greece, where the social services until recently concentrated on institutional care, there has recently been a change of direction, for example through the home care programme of the Greek Red Cross.

During 1992, the Observatory undertook a special study of the social services of the Community countries, with reference to social exclusion. This synthesis report is based upon national reports prepared by the members of the Observatory, independent experts who are listed below. It accompanies the general report which the Observatory also produced during 1992 concerning national policies to combat social exclusion (Room et al, 1992).

The Observatory was created at the beginning of 1990 by the Commission of the European Communities, Directorate General V (Employment, Social Affairs and Industrial Relations). It operates under the responsibility of Division V/C/1 (Social Security and Actions in the Social Domain). The report does not necessarily represent the views of the European Commission and final responsibility for the report rests with the Observatory coordinator.

As is stressed throughout the report, the data which are properly required for our work are in many cases not available or are of only limited comparability. For better or worse, it is those countries with the most well developed data systems which are probably the most visible in our analysis: as regards both the achievements and the limitations in their policies. We do not provide, for each section of our report, a detailed inventory of the data available and the most obvious gaps; but this is an exercise which could be undertaken if necessary.

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CHAPTER 1: INTRODUCTION

1.1. INTRODUCTION

The Observatory is charged with studying the whole range of national policies to combat social exclusion. This is intended by the Commission to benefit national policy makers who will, on the principle of subsidiarity, remain responsible for the broad range of social and economic policies [1].

Nevertheless, the usefulness of the information which the Observatory collects is also to be judged in part by reference to the needs of the Commission itself, as it prepares a range of policy proposals within the context of the Action Programme to implement the Charter of Fundamental Social Rights of Workers, as well as the more recent agreements at Maastricht. During 1992, one of these needs has been to explore problems of access to social services, with a view to possibly preparing an initiative in this area. Such an initiative would be consistent with the attention given to services for elderly and disabled persons within the Action Programme of 1989; and it would complement the draft recommendation on sufficient resources and social assistance which was approved by the Council of Ministers in June 1992 and which is concerned with cash benefits.

Access to community services is mentioned within the Council Resolution on Social Exclusion (89/C277/01), the principal point of reference for the work of the Observatory. However, it formed only a minor element of the Observatory's work during 1990-91. This was for three reasons. First, within many countries the data are unavailable, as well as there being problems of cross-national comparability among those that are. Second, there are great difficulties in defining the "social services" in a way that can command general agreement. Third, the sponsorship of the Observatory by the European Social Fund encouraged a concern with labour market and employment issues, rather than social services.

1.2. THE THEORETICAL PERSPECTIVE

We define social exclusion first and foremost in relation to the social rights of citizens. Within the countries of the EC, it is generally taken for granted that each citizen has the right to enjoy a certain basic standard of living and to participate in the major social and occupational institutions of the society. This right may be expressed in legal terms: in the case of the social services, in general it is not. However, such social rights are regularly reaffirmed in policy statements at both national and Community levels and they reappear in the Community legislation which provides the terms of reference for this Observatory.

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[1] For a general overview of the work of the Observatory - ist terms of reference, its manner of working, its theoretical perspectives - please see the introductory chapter to our General Report (Room et al., 1992).

Social exclusion can be analysed in terms of the denial - or non-realisation - of these social rights. An essential part of the Observatory's work is to study the extent to which the public authorities have been effective in implementing the citizenship rights which are implicit or explicit in their own declarations. But we then go on also to examine the barriers by which people are excluded from these rights; and the processes of generalised and persisting disadvantage which they may then suffer, along with their reduced levels of social and occupational participation.

The comparative study of different national systems can be particularly illuminating: first, to display the extent to which these processes of exclusion reappear, in the same form and to the same extent, in different social systems; second, to reveal the political choices which different countries have made as to the public effort that should be devoted to combatting specific forms and processes of exclusion.

It is in terms of such a theoretical perspective that this study of social services will be developed.

1.3. THE POLICY BACKGROUND

Our studies are conducted against a background which is itself changing. Economic and social changes produce new risks of social exclusion, as our general reports have revealed. Some of these are of particular concern to the social services and will therefore receive attention in this study.

Many of the social problems faced by the social services are, of course, similar among the various Member States: the ageing of the population, the reinsertion of those on minimum benefits, the return to normal community living of those who were formerly in institutions, the surge of immigration from the south and the east. However, the ways in which these problems are perceived and the responses which are made depend very much on the sort of welfare regime in the country concerned. In Belgium, for example, where welfare services have traditionally been organised in terms of the ideological or confessional "pillars", recent public debates on immigration have involved resistance, in particular, to the subsidising of new "pillars" for immigrant groups who want to organise their own religious and cultural institutions. In Germany, there is growing concern about the capacity of the Bismarckian social insurance system to provide long-term social care for the elderly. In the United Kingdom, developments in the social services - as well as in other areas of social policy - are being driven by the central government's wish to promote a "mixed economy of welfare".

The perceptions which key decision-makers hold of different social groups and of different types of exclusion, and the efforts devoted to combatting that exclusion, can be somewhat volatile. Thus, for example, Spain has in recent years seen rising marginalisation of drug addicts, Gypsies and black immigrants and social movements hostile to drug users have developed. This contrasts with developments there in relation to women, for example, whose social rights have been considerably strengthened (in relation to alimony payments, domestic abuse, access to the labour market, family planning and health care). In public debates in Italy, drug addicts and Third World immigrants are commonly perceived as the most acute social

problem - but probably because they are perceived first and foremost as presenting a problem for social order, rather than because of concern for their social rights. Much less visible are children living in stressful situations, multi-problem families, "ordinarily poor" families and adults, school drop-outs and inadequately educated and skilled young people, with no behavioural "problems". This, again, contrasts with the situation in the United Kingdom, where something akin to panic over children at risk of abuse has dominated public debate over the social services in recent years, driving service providers - especially in the public sector - to make child welfare their priority.

1.4. THE SOCIAL SERVICES AND SOCIAL EXCLUSION

The social services with which we are here concerned are those which take as their principal aim to support - and perhaps refashion - family and local community networks which are under stress and to reinsert individuals into such networks. They therefore have a particular interest for an Observatory which is concerned with social exclusion. This is because individuals who lack these networks - whose relationships with family and local community are precarious - are likely to be particularly vulnerable at certain stages of the life cycle - birth, sickness, old age - especially if their command over resources in the market place is also insecure.

Traditionally, social service of this sort was the concern of the churches rather than of the public authorities. Thus in Luxembourg, for example, it is only since the first World War that lay organisations and the public authorities have ventured into this field and only since the 1960s that they have taken a major roles: on the one hand to recognise declining personnel resources of the Church, and on the other to challenge the persistence of traditional forms of social service, concentrated on institutional care. In areas of the European Community where the Church and its welfare organisations remain politically influential, social services are to some considerable extent still under their control. Admittedly, the financial resources required come largely from public sources; nevertheless, their capacity to approprate public funds on this scale confirms their power, rather than putting it in question.

Nowhere is this more obvious than in relation to poverty and social exclusion, which have always been central to the social role of the Church and to its "sphere of influence", but as objects of charitable rather than political action. This perception is reinforced by the widespread activity of the Church's many voluntary organisations, mobilising service by the laity. But this can be inimical to the development of secular rights of citizenship (cf. Bruto da Costa, 1987, pp. 5-6). On the other hand, the cultivation of secular citizenship as a goal of public policy commonly involves efforts to exclude foreigners - a concern much less evident, and even absent, from the services administered by the churches, where confessional allegiance has in general been more important.

The central role of the churches may also have had consequences for the development of local government. Whereas in the United Kingdom, for example, local government developed its powers largely around responsibilities vacated by the Church (notably education and the relief of poverty), in countries where the Church has retained its dominance local government has been slower to develop. Nevertheless, in countries such as Italy, Spain and

Portugal, recent years have seen efforts to expand the role of local and regional government, not least as regulatory and coordinating bodies.

The social services as an element of the social policy of the public authorities therefore remain in several countries ill-defined and under-developed relative to other elements. Spain, for example, has only recently created a set of national strategies for social service development: before that, the public services played a highly residual role, within which difficulties of fragmentation and coordination were very evident. As a proportion of GNP, expenditure on public social services rose more than three-fold between 1972 and 1988, but even in the latter year was a mere 0.88%, compared with 6% in Denmark. This residual role continues to characterise some other countries, including Greece, where traditional charitable activity by the Greek Orthodox Church and its welfare organs remains important relative to the public sector, especially in such fields as residential care of the children and the elderly and the introduction of new programmes for the reintegration of Greek migrant workers returning from Germany. (This rudimentary development of public social services in Greece may, of course, reflect the continuing importance of family ties in providing social support to those who are vulnerable, although it is of course difficult to disentangle cause and effect.) And even in as economically advanced a country as Germany, the development of public social services has been constrained by the predominance of private services on the one hand, health insurance on the other (cf Sections 2.2, 2.4 below).

In Ireland also, the social services do not comprise a clearly defined policy area, there is no official demarcation of the field, and no one responsible minister, government department, budget heading or type of executive agency. In many countries, services remain fragmented and organised under the responsibility of different public authorities: different in terms of function (health, social security, etc) and different in terms of level (local, regional, national). What nevertheless may give them a certain identity are the professional skills and training which these services involve. Their relationship to other arms of social policy is equally varied. In some cases, the link with health care is strong; in others, with cash benefits. Indeed, in some cases these links are so strong that it is difficult to study the social services in isolation.

The social services can include advice, advocacy and legal services. In some countries these services remain focussed on specific population groups which are particularly vulnerable when their support networks of family and local community are weakened: the old and the young, the mentally and physically disabled, those who have only recently arrived in the country concerned, those recently discharged from institutions of care and control. Thus, for example, in Belgium, the social services have traditionally been - and still largely remain - focussed on the delivery of particular services to specific population groups.

In support of family and community networks, social services sometimes become involved in community development on the one hand, the promotion of volunteering on the other. The latter commonly involves individuals who are not themselves disadvantaged donating their time and energy to organisations which are supplying services to various needy groups; the former normally involves the building of self-help and mutual aid networks within communities which are generally disadvantaged, and the strengthening of their "voice" vis-à-vis outside decision-makers. Both involve what the French term "social action": efforts to mobilise citizens as participants in social functioning, outside the narrow confines of the market place on the one hand, one-sided dependance upon the public authorities on the other. The

social services sometimes also become involved in promoting the "caring capacity" of the family and the local community, notably in relation to programmes aimed at switching from institutional to community-based provision for individuals and groups at risk. But it cannot be taken for granted that local communities which are suffering various forms of disadvantage are able to offer a caring capacity in support of these dependent groups: and wider social and economic policies are therefore of fundamental importance.

The family and the local community - and hence also the social services which seek to support them - are concerned not only with care and support but also with discipline and control. But this is not peculiar to the social services narrowly defined. For example, in the field of social security, officials who dispense cash benefits to the unemployed commonly seek to enforce work obligations and to promote occupational reinsertion, with only a limited range of individual choice being left to the claimant before sanctions are applied; and those who dispense cash benefits to lone parents may seek to enforce the obligation of the absent parent (usually the father) to provide financial maintenance. Citizenship involves the social enforcement of duties and obligations, as well as the appropriation of rights.

Social services have sometimes to replace - rather than merely to support - family and community networks. Institutional provision therefore falls within their scope. It is more difficult to decide whether the penal and probation services should be included, as dealing with social discipline and the control - whether in institutions or in the local community - of individuals who are "at risk" of offending. In principle they should probably be included; however, for practical reasons and to limit somewhat the scope of our study, at this stage they have been omitted.

1.5. THE PUBLIC SOCIAL SERVICES AND OTHER SECTORS

The public sector social services form the starting point for this study. But the commercial sector must also be considered: for example, in providing nursing homes for elderly people. And some employers provide support to the families of their employees which cannot easily be distinguished from the support which the public social services provide. For example, during the 19th and 20th Centuries important social services grew up around the steel industries of Luxembourg, Lorraine and the Ruhr: family centres, holiday centres for children and vocational training schools, as well as housing, social assistance, medical care and hospitals.

The voluntary or not-for-profit sector is also heavily involved. In Luxembourg, again, it is the voluntary sector that runs the nation-wide network of medico-social centres within the 118 communes, albeit with public funding and within frameworks set by the State. Promotion of the voluntary sector in providing social services is, moreover, in some countries a key objective of public policy: whether we are thinking of large-scale NGOs or "volunteering", the altruistic donation of time and effort by particular lay individuals. Thus in Spain, for example, the government is currently promoting the development of the voluntary sector, not least through new proposals for tax deductible donations by individuals and firms: something that has long existed elsewhere. Consultative boards have been created, to involve NGOs in the development of national plans on women, drugs, etc. In Ireland, in face of criticisms of the

lack of any framework within which the voluntary sector can develop its contribution to the social services, a Charter for Voluntary Service has been promised by the government. However, the dependence of NGOs on government funding has in some countries - the UK and Luxembourg for example - provoked anxieties that they will have less scope for advancing their own distinctive priorities.

As well as being involved in the actual delivery of social services, these NGOs can play an important role in defining social rights and the boundaries of public policy. In Greece, for example, what seems to have happened in the field of disability is that self-help and charitable associations concerned with specific disabilities have put pressure on the public authorities to legislate the rights of these disabled to specific social benefits and services: the nationalisation, in other words, of previously private and voluntary initiatives. In many countries private organisations act as pressure groups and advocates for specific needs, e.g. disabled people, some of these being patient-led self-help groups, as in Denmark for example. This can, indeed, mean that public opinion is shaped by specific NGOs which have "colonised" particular social needs, to the neglect of others.

Any comprehensive study must take account of these different sectors of welfare, their inter-relationships, and changes in their relative importance. The extent to which these various sectors operate under the supervision and regulation of the public authorities - and perhaps with their financial support - is of course also an important policy question.

1.6. METHODOLOGY OF THE STUDY

We have been charged with studying the efforts of the social services within each member state to combat social exclusion. This raises specific difficulties, additional to those which pervade our work in general (see our General Report: Room et al (1992), Section 1.5).

Firstly, an Observatory which is located at Community level will tend to concern itself not with intra-country variations in efforts to combat social exclusion but with national "averages" and typical cases. However, perhaps more than with any other branch of public policy, the social services tend to be organised and developed at the local level, with considerable local variation, and it is difficult to delineate any "average" situation for the country as a whole.

Secondly, in this area, more perhaps, than any other, the work of the Observatory is limited by the lack of up-to-date and comparable data on patterns of social exclusion and on the effectiveness of different social services. This is in part because of the local organisation of services to which we have just referred, which militates against the collection of organised bodies of data, even within a single country. But it is also because of the low status enjoyed by some of the population groups with which these services deal and their low levels of political visibility.

Some of our national experts have sought to overcome these data deficiencies by going directly to the relevant agencies, in order to investigate their actions and policies. More than in our general studies, they have resorted to interviews with policy-makers and other experts. In

addition, we have collected data on the minimum levels of service which are available in each country for certain well-specified groups of clients, which can thus serve as points of reference for more rigorous cross-national comparisons (see Chapter 3 below)

1.7. CONCLUSION

The varying focus of the twelve national reports and the differences in the quality and availability of data, as between the different countries of the Community, mean that this report is illustrative rather than comprehensive. Within the Observatory team, we have striven to develop and to use a common framework, in order that a systematic comparative analysis will be possible for this European report; but the centrifugal forces at work within any multi-national team, driven by twelve different national contexts, seriously limit this endeavour. We can, at most, indicate some of the common policy approaches being used and, in some cases, present evidence as to their effectiveness.

This report is structured in four parts. Chapter 2 is concerned with the boundaries of the social services, their functions and inter-relationships, insofar as these shape their responses to social exclusion. Chapter 3 deals with specific policies and services: the entitlements which they accord to citizens their coverage, their effectiveness and the barriers to access. Chapter 4 examines some of the processes of generalised and persisting disadvantage that people suffer as a result of the inadequacies in the social services, along with their reduced levels of social and occupational participation. Finally, Chapter 5 is concerned with the extent to which national governments are already looking at each other's experiences in this field, as they design their own interventions, and the ways in which the Community institutions might, in accordance with the principle of subsidiarity, support these actions.

CHAPTER 2 : PUBLIC POLICY AND THE ORGANISATION OF THE SOCIAL SERVICES

2.1. INTRODUCTION

As seen in Chapter 1, we define social exclusion first and foremost in relation to the social rights of citizens. We examine the processes by which people are excluded from these rights; and the processes of generalised and persisting disadvantage which they may then suffer, along with their reduced levels of social and occupational participation.

Hardly anywhere in the Community are the social services delivered by central government itself. Even where central government specifies policy objectives, the task of implementation is in general the responsibility of regional and local government or private organisations. In both cases the question of regulation arises: how far do the public authorities in general, and central government in particular, monitor and supervise the performance of these "lower" actors? And how far does this involve the specification of particular standards of service provision?

But there is a second question also. To speak of social rights presupposes that a matter of public, rather than merely private, interest is at stake. Social rights involve claims on the public authorities, even if these authorities choose to exercise their responsibilities through private agencies. We are therefore interested not only in the extent to which the public authorities are effective in implementing the social rights which are implicit or explicit in their own declarations, but also in the range and volume of the rights that have been declared. In some countries, matters which elsewhere have been placed firmly in the public domain, as rights of citizenship, are left as a private matter.

This chapter examines the organisation of the social services in terms of the public policy choices which have been made in different countries of the Community. More specifically, it focusses upon three key issues:

* the role of public and private agencies, involving considerations of "privatisation", the "mixed economy of welfare" and "horizontal subsidiarity";

* the role of central, regional and local government, involving considerations of "decentralisation" and "vertical" subsidiarity;

* the relationship between the social services and other branches of social policy.

The Annex to this report displays the resulting cast of actors.

Throughout, these issues are examined from the standpoint of citizens' social rights and the implications for social exclusion.

TABLE 1: PUBLIC AND PRIVATE PROVISION OF SOCIAL SERVICES

BELGIUM Number of homes for the elderly in Flanders: 1.3.90: public-private						
	HOMMES		**BEDS**			
Public	31.9%		42.0%			
Non-profit association	39,1%		44,6%			
Commercial	29,1%		13,6%			
Total	100%		100%			
IRELAND Number of persons in homes for the elderly: 31.12.89: public-private						
	PERSONS		**% AGE**			
Public	1358		15,8%			
Voluntary	4895		57,0%			
Private	2335		27,2%			
PORTUGAL Number of Residents in Public and Private Residential Homes covered by cooperation agreements with Regional Social Security Centres 1990						
	CHILDREN		**DISABLED**		**ELDERLY**	
Public	34,3%		4,8%		14,1%	
Private Solidarity Institutes	63,6%		81,5%		85,7%	
Misericordia dia Lisboa	2,1%		13,7%		0,2%	
ENGLAND Number of persons in homes for the elderly and for younger physically handicapped people on 31st March each year: public-private						
	1980		**1986**		**1990**	
	PERSONS	**% AGE**	**PERSONS**	**%AGE**	**PERSONS**	**%AGE**
Public	107852	84%	106232	93%	91100	94%
Voluntary	16730	13%	6710	6%	5100	5%
Private	3552	3%	905	1%	1000	1%

2.2. PRIVATISATION AND HORIZONTAL SUBSIDIARITY

In many countries of the Community, private organisations - some commercial - play a significant role in delivering social services (see Table 1). In some cases, this involves the receipt of public funds, while others, it involves an agreement as to the standard of service that will be provided However, in part because of the difficulty of defining such standards, and in part because of resistance by these organisations to external regulation, precise agreements of this sort are often lacking. The result can be that while there is an extended network of social

this sort are often lacking. The result can be that while there is an extended network of social services, there is great scope for neglect, discretion and arbitrariness in service provision, but with little monitoring of what is provided or of how effective it is.

The low level of public services in some countries may make the existence of these private services appear indispensable. However, the obscurity of what these services do - as far as the public policy debate is concerned - means that citizens' social rights are very weak. Debates about the regulation of these private activities are thus in part concerned with their efficiency and effectiveness in the use of public subsidies; but they also concern the standards of service to which citizens are entitled - a question of social rights

Among the countries of the Community, it appears to be in Denmark that non-governmental organisations play the most limited role in the formulation and implementation of public policy on social services. Admittedly, in the field of institutional provision private organisations play a more substantial part, albeit under contract to municipalities: one third of all day care and residential care and one quarter of nursing homes. But through the 1980s, their weight was falling. Private organisations are also - and always have been - significant in relation to the most excluded groups, for example drug addicts. Some provide social services for children. And large numbers of such organisations are to be found in the fields of health and disability, working in part as pressure groups, shaping public opinion, but also offering specialised services for particular conditions. Thus, for example, the Rheumatism Association, as well as its publicity work, also provides special hospitals, technical aids and advice services to sufferers.

However, the great bulk of social services in Denmark are provided directly by local authorities. Where private organisations do receive public funds, they are tightly controlled by the responsible public bodies - in terms of their management, the services offered and the financial accounts rendered; their main role is to offer counselling and advice, rather than direct services. Nevertheless, the Conservative-Liberal government of the 1980s sought to incorporate networks of citizens into social work, to involve private and voluntary organisations and to support social experiments and development projects. 1983 saw the establishment of a National Committee on Voluntary Effort. In addition, development funds have been established by various Ministries (e.g. the Ministry of Social Affairs: SUM) to support new initiatives by local communities: projects which bring together a variety of local organisations and groups in new partnerships.

In the United Kingdom, another country with a traditionally strong public sector in the social services, there is growing use of private sector agencies, but within the framework of contracts which stipulate specific standards of performance and reporting. Under the Children Act (1989) and the Community Care Act (1990),(2) local authorities are being given new responsibilities for arranging a package of care for each client, drawing upon a variety of public and private sector services, but without themselves necessarily being the principal providers. The local authorities are involved in monitoring the quality of service provided by commercial organisations and NGOs; and indeed, during the 1980s many of the latter came increasingly to depend on local or central government funding, with some reorientation of their goals as the counterpart to regulation. As for the commercial sector, its growth has in some fields been

(2) Both these Acts apply to England and Wales only

spectacular: notably residential care for the elderly. This privatisation of services is informed by a political vision of the liberal market society and the central government's wish to promote a "mixed economy of welfare".

In France, notwithstanding the very different political complexion of the government from that in the UK, recent years have similarly seen increasing use of commercial organisations to provide social services, on the basis of contracts setting clear standards of service. At the same time, however, the non-profit sector remains very important in certain fields, including for example home care and sheltered housing for the elderly.

In Spain, the NGOs which provide social services remain highly dependent on State funding, more an extension of the State than autonomous organisations, and providing services rather than being channels for social participation. In Portugal, certain private social solidarity institutions, most linked to the Church (at least in their origins), provide social services under cooperation agreements with the Regional Social Security Centres, the principal administrative authority for the public social services. Their importance is growing. Even as between 1989 and 1990, the growth of public subsidies to these private sector social services was 42%, while the growth in expenditure on social services ("social action") as a whole was only 30%. As Table 1 reveals, they play a very major role in residential care of elderly and disabled people.

In Luxembourg, a variety of "conventions" between the central government and private organisations regulate the social services which the latter provide, involving different degrees of control and supervision by the former. These stipulate standards of service (including, for example, ratios of staff to clients). Hotly debated, however, is whether such conventions should be underpinned by legislation, rather than having the status of mere administrative regulations. Such legislation would enhance the role of the public authorities as regulator if not as provider and it would be debateable in what sense the private services remained "private" at all.

In Ireland, private agencies predominate in residential services for children and elderly people. (Table 1 reveals that in the latter case at least, the public sector plays a substantially smaller role than even in Flanders, where a strong liberal and Catholic tradition has long given the public sector a smaller role than in Socialist Wallonia.) Private agencies also predominate in services for mentally handicapped people in Ireland. In some cases, social service councils (bringing these agencies together at the local level) deliver a range of health, welfare and child care services on behalf of the health boards and thus serve almost as part of the statutory services. Nationally, the Social Services Board sets standards and provides training, consultancy and advice to support the development of local services; but more recently these have been undertaken, increasingly, by the regional health boards. However, there is substantial regional variation in the services offered by these NGOs and they are only loosely regulated. There is no formal framework or procedural guidelines for the relationship between statutory and voluntary bodies, so as to ensure their complementarity. Procedures for making contracts or agreements, for funding and for liaison can vary greatly.

In Italy, there are fewer public and private services in the South than in the Centre and North. As for the balance between public and private, this also varies. The South has a preponderance of voluntary services and private - often commercial - agencies which are under contract to local authorities; in the Centre and North, public services, social cooperatives and

non-profit agencies predominate; in the north-east, voluntary services are again prominent, supplementing the public services. These variations are in part the result of a stronger ideological emphasis on public provision in the urban areas of the centre and north. But the preponderance of the private sector in the south may also, it is often alleged, be an expression of the clientelism which many analysts have identified within Italian political life.

In the Netherlands, private provision of most social services during the present century has predominated, but as an expression of "pillarisation". In the period between 1900 and 1960, the most important social organisations did not develop according to socio-economic criteria; socio-economic divisions such as those between employers and employees were less important than differences between socio-cultural groups based on religious or ideological principles. Government filled only the gaps that were not covered by these private organisations.

Following the Second World War, the social services offered by these Dutch pillars became increasingly dependent on public financing, but were not subject to concomitantly greater public control. Lack of coordination among agencies linked to different pillars, but offering complementary or similar services within the same local area, was the subject of frequent criticism (cf. Brenton, 1982). Since the 1960s "pillarisation" has been in decline, and any new organisations which have been formed have not, in general, been linked to a pillar. Moreover, some welfare organisations previously in allegiance to different pillars have merged. Nevertheless, many social service organisations still bear the marks of their origins in discrete pillars.

It is in part by reference to these changes in recent decades that the Social Renewal Policy of the 1990s can be viewed. As the pillars have decayed, a plethora of services has been left behind whose fragmentation now has little rationale. The Social Renewal Policy, which has established new powers for local government in the social and employment fields as well as attempting to devolve central government power, accompanies the move from a society where these policies are the responsibility of the pillars ("horizontal subsidiarity") to one where, to a greater extent than previously, they are the responsibility of the local municipalities ("vertical subsidiarity"), even if private agencies continue to play an important role in realising the plans of the municipalities. Central government funding of pillars gradually gave way, during the 1970s and 1980s, to central government grants for specific projects and now, under the Social Renewal Policy, to lump sum grants to municipalities (Pijl, 1992, p. 3). Within this devolved system, central government retains responsibility for national organisations which support local organisations by means of information and training, for example; and for organisations deemed to be of particular importance nationally, for example refugee centres for women.

In Germany, under the principle of subsidiarity, the private non-profit welfare organisations, with 750,000 employees, as well as 1.5 million volunteers and part-time workers, and an annual turnover of 40-50 billion DM, play a major role in the delivery of social services. The balance between public and private varies among the Länder, however, with only the primary cash support offered by social assistance and the legally mandated tasks of child welfare being reserved specifically for public agencies (Landwehr, 1992, p. 17). Otherwise, these non-profit organisations are entitled to choose which services they shall offer in a given region. Their role may now be under threat, however, at least as far as better off clients are

concerned, as commercial organisations enter more energetically into the field of social care, for example in relation to the elderly.

The private organisations are then in large measure reimbursed their costs from public funds (Landwehr, 1992, p. 19). The remaining funds come from their own resources (including the church taxes which government collects on their behalf). However, they are subject to only rudimentary financial reporting and public accountability for these funds and it is difficult to know the extent of the contribution from their own resources. (Equally, no estimate is available of the contribution in kind which comes from their volunteers: Landwehr, 1992, pp. 19-20). This is, of course, in marked contrast to the degree of public regulation of private providers seen above in the cases of Denmark and the UK. Finally, there is no obligation for them to act in accordance with the social plans of the municipality, even though it is from the municipality that they are largely financed and they may even act in contradiction with those plans. As in the Netherlands, therefore, although the plurality of these welfare organisations to some extent makes for diversity and choice, it can also serve as an obstacle to coherent planning and coordination.

But subsidiarity is not just a matter of the relationship between different levels of government on the one hand, and between governmental and non-governmental agencies on the other. It also extends to the role and responsibility of the family itself, and the extent to which this is seen as a private or public matter. Here again, Denmark appears to lie at one extreme. There is little expectation that children should be responsible for their elderly parents. On the contrary, the first and principal responsibility for social care lies with the municipality. In Germany, in contrast, it is first and foremost the family which is held responsible for such care. Where the municipality is obliged to step in - for example, for the social care of an elderly person - the income test which is applied takes into account the resources of that person's relatives also. The obligations of family members to each other which are implied by these income tests are common in other countries also, although increasingly they are being contested and they stand in sharp contrast to the individualisation of benefits to be found in social insurance schemes.

2.3. DECENTRALISATION AND VERTICAL SUBSIDIARITY

Throughout the Community, with the sole exception of Greece, major responsibility for the social services rests with regional and local, rather than with central government. In many cases, only the general framework of policy objectives is established centrally, leaving regional and local authorities to fill in the detail, in some cases by local legislation.

Significant changes have been taking place in the division of these responsibilities. These changes are being variously debated in terms of decentralisation, local autonomy and "vertical" subsidiarity. They can affect the channels by which ordinary citizens participate politically and secure their social rights. For example,

* in the Netherlands, the Social Renewal Policy involves significant increases in the responsibilities of local authorities for efforts to combat social disadvantage, not least in relation to the social services; the same goes for the Welfare Act of 1988. Thus between 1975

and 1990 the proportion of public expenditures on social welfare undertaken at the local, **rather than the provincial or national level, increased from 9% to 15.6%;**

* in Belgium, recent years have seen devolution of administrative responsibilities to the regions and communities; the latter now have responsibility for family policy, the reception and integration of immigrants, and policies for people with disabilities (including vocational training and retraining) elderly people and ex-offenders. (Mostinckx, 1992, p. 6). Flanders in particular has developed its own policies for combatting social exclusion, which include initiatives aimed at the social integration of migrants;

* in Spain, a Concerted Plan of Social Services was agreed in 1988 between the central, regional and local administrations, aimed at developing local centres of social services and harmonising policy objectives. This can, in part, be seen as an attempt to avoid excessive dispersion and variation in services, as a result of the decentralisation of responsibilities to the regions. National Plans have also been established in related areas, including equal opportunities, drugs, youth and elderly people;

* in France, the decentralisation of major areas of policy to the departements and the municipalities have substantially changed the financial and organisational imperatives which face service providers. Thus, for example, the Centres for Shelter and Social Readjustment (CHRS) (see Section 3.3.5 below), offering emergency shelter but also aids to reinsertion, are now obliged, as a condition of these aids being financed by the d,partement, to associate themselves with a range of other local agencies, according to current notions of "partnership";

* in the UK, developments in the personal social services are reinforcing the role of local authorities (but in the context of a more general shift of power from local to central government). The new Children Act (1989) and the Community Care Act (1990) place new responsibilities on the local authority to arrange for the provision of services, if not to provide them itself. Here, as in Spain, local authority planning of social care - for the individual client and for the local area - has been central to this recent legislation, incorporating specific targets against which performance can be judged.

Taken in conjunction with the forms of privatisation and "horizontal subsidiarity" which were examined in the previous section, these developments have produced a wide variety of roles for local government in different countries. For example:

* in Denmark, the local authority acts as unitary purchaser and provider of social services;

* in the UK, until recently social care was provided by the local authority as well as by non-profit and commercial institutions, with funding coming in part from the Department of Social Security (residential care), in part from the local authority. However, the local authority now acts as the unitary purchaser from multiple providers, arranging packages of care for vulnerable groups and monitoring their quality and their cost-effectiveness;

* in Belgium, the local public social service centres (CPAS/OCMW) are run by councils appointed by the municipality, but they are formally separate from local government. As well as providing services themselves, they act as the central coordinator of the wider range of

services which other organisations supply. Their expenditure on income support is subsidised by the national government, but their services depend on funding from the communities and the local municipalities;

* in Germany, it is a local social centre (Sozialstation), normally run by private welfare organisations, that acts as the unitary provider of ambulant social care but which then reclaims the costs from multiple purchasers/funders: the health insurance funds (if the social need has been defined as medical), the family (if above a certain income level, according to a means test) or the local authority (if the family is poor).

Corresponding to these variations, there are substantial differences in the powers of local authorities to regulate private providers, to ensure coherence of their activities and to secure their conformity to any long-term local planning for meeting social needs. In the UK, the local authority holds the purse-strings and can purchase care for its clients on the basis of the criteria of social need which it establishes. In France, contractual agreements between the public authorities and private providers are becoming more frequent, incorporating specific standards of performance. In Germany, in contrast, (and in Belgium and the Netherlands, until recently at least) substantial sums of public money are handed over to the confessional welfare organisations, which then apply their own criteria (social need, income, confessional allegiance) in administering the services which these funds finance. This allocation of funds, coupled with the ideological preference for the public sector to act only as the last resort, under the principle of subsidiarity, means that in Germany the local authority has a much less significant role than in the UK.

2.4. THE SOCIAL SERVICES AND WIDER SOCIAL POLICY

The social protection systems of western Europe which have developed during the last 100 years have centred in systems of social insurance: insurance for workers against the risks of income insecurity arising from sickness, industrial accident, unemployment and old age. These systems grew up alongside the remains of older, pre-industrial systems of local charity, organised variously through the churches or through municipalities, and offering care, support and discipline for the poor.

Social services and the care which they offer lie uneasily between the two systems. In some cases efforts have been made to expand the range of insurable risks in order to include the funding of social care, elsewhere, social services have developed out of the pre-industrial system of local charity, although the extent to which they remain services for the poor varies greatly. And the matter is of course complicated by recent and continuing changes in patterns of poverty in the countries of the Community.

In Germany, the Bismarckian social insurance system remains centre stage [3]. Much recent debate has been concerned with the extent to which long-term social care - for elderly people in particular - can be funded from within health insurance. But outside this insurance system, the first responsibility for providing social care lies with the family, then with the private - commercial and confessional - welfare organisations. Only when they cannot meet people's needs does the responsibility fall, on the principle of "vertical" subsidiarity, to the public authorities: the municipalities, the Länder and finally the Federal Government. However, the test of need for these public social services is an income test, and these services thus remain services for the poor (Jamieson, 1991, pp. 110-116).

The result is that a person or family in need of support by the social services has two principal options, other than using their own private resources or seeking support from one of the confessional welfare organisations. First, to submit to the ignominy of a means-test in relation to the public social services: an ignominy that is the greater, the more that private welfare organisations cater for groups which are seen as more "deserving" or morally reputable. Second, to have their social needs recognised as including a medical element, in order to be covered through health insurance. However, the insurance organisations are reluctant to include non-medical services under the umbrella of health insurance, because of fears of cost escalation, which would follow "if social services began to be seen as a right, and not, as hitherto, as a highly stigmatised means-tested safety net for the poor (Jamieson, 1991, p. 116). One third of the costs of social assistance now go on support for care of the elderly (10 billion DM out of 31.6 billion in 1990); and it is this cost explosion that has, in part, fuelled debate about the establishment of "nursing care insurance for the elderly" (Landwehr, 1992, p.2).

These options reappear in a number of other Community countries. In Belgium, the local Commission for Public Assistance (CPA) until 1976 dealt with the poor alone and to appeal for its aid was highly stigmatising. From that year, these were replaced by Public Centres for Social Welfare (OCMW/CPAS), open to a wider range of citizens and offering the right to specific social services. Nevertheless, some of the former stigma remains. In France, similarly, the legacy of the poor law overshadows many social services, a reputation for administrative inefficiency compounding their stigmatisation.

In Italy, although some local social services are available for all of those in priority social need, charges are levied and these are means-tested. For some local social services, an income test is used to exclude the non-poor entirely. Thus, for example, home helps for the elderly are available only to those who already receive means-tested income support. Only recently have day care services for children under the age of three lost their social assistance label, dealing with the special needs of "problem families", and they still have an ambiguous status. In contrast, day care services for pre-school children aged above three years have had a broader, educational status since the 1950s, and are universalistic. And whereas social assistance and the social services are a local responsibility, with a strong element of discretion

[3] Notice that the Bismarckian system involves a further expression of subsidiarity: the devolution to the social partners of the management of social insurance. These organisations, although public law bodies, are non-governmental and the State itself intervenes minimally ("horizontal subsidiarity"). But this means, inter alia, that these "insurance organisations are dominated by the labour market organisations, i.e. employers and employees, and concern for [the long-term social care of] older people is not very high on their agenda" (Jamieson, 1991, p. 115).

in their administration, education, like the health service, is the direct responsibility of central government: **both tend to be universalistic and to involve social rights. As in Germany,** therefore, it tends to be only insofar as social services are associated with the "universalistic" elements of social policy - education and health in particular - that they lose their links with traditional charity for the poor.

Even so, the extent to which social services are integrated into those universalistic systems is in some countries very limited. In Germany, social care which is funded through health insurance can include specialised nursing care and home help, but only for up to four weeks. Even this depends on whether the person is already undergoing medical treatment and, to repeat, whether this social care is identified by the doctor as being in support of the medical treatment (Jamieson, 1991). In Luxembourg the situation is similar, with costs deemed medical being borne by the health insurance funds for six months, but thereafter the costs being shared between the person concerned and, subject to a means test, the State: current debate centres on the prospects for expanding the range of social care covered by health insurance. In contrast, in Ireland (northern Ireland as well as the Republic, but not the rest of the UK) the public social services are an integral part of the health service itself: a degree of administrative integration not found elsewhere in the Community.

German efforts to expand the extent of social care funding under the health insurance system find their counterpart in the Netherlands. Here, the Exceptional Medical Expenses Act (1967) was originally intended to cover long-term disability or costly illnesses. Now, however, it also includes some elements of care which are not particularly long-term or serious, including care in nursing homes, care at home and home helps Indeed, the costs of more and more health and social services are being transferred from health insurance to the Exceptional Medical Expenses Act, which will progressively become a compulsory insurance scheme covering the whole population and most social and health services. Even so, this reform remains politically contentious and it may not wholly succeed [4].

Denmark is different. There, social services have been freed entirely from being services for the poor, but without their being made subservient to the health or education systems. Local Government Reform in 1970 gave the municipalities a solid organisational and financial basis (local taxes) and paved the way for decentralising to the municipalities unitary responsibility for social services. These services now constitute a high status sector of public activitity, not least in terms of the volume of public resources which they consume (more, indeed, than health care). There may be charges for services, but the services are open to - and are used by - the whole range of the population, who present themselves at a single location for assessment of their needs. For example, home help will be provided to an elderly person free of charge, on the basis of social need as assessed by the local authority. Neither health condition nor income play a part in this assessment, even if charges are then made which depend in part on income. Access to social services is thus a citizenship right rather than an insurance right, as in the current Dutch and German reforms.

[4] It is important to notice that under a Bismarckian system of social insurance - and in this respect at least the Dutch system is Bismarckian - contributions come from employers and employees. In contrast, under the Dutch reform contributions will come also from Government (and thus from public taxation), even if there are hopes that this will remain below 10%. A Bismarckian system will normally place severe limitations on coverage of the risks of long-term social care. Ultimately, only general taxation can underwrite such a commitment.

It is evident, then, that the social services vary substantially in their relation to the systems of social assistance, social insurance and health care. This can have important consequences for the political priority which is given to social services expenditure. Thus, for example, in Italy, increasing responsibilties for social needs are being assumed by the municipalities - drug addicts, AIDS, immigrants - but the social budget is being cut and has less legitimation than health expenditure.

Also important, however, are the links of the social services to employment services and policies. These links go back, of course, to pre-industrial times, when the Poor Law, as well as providing charitable relief, also exerted pressure on the able-bodied poor to redouble their efforts to support themselves through labour. On the other hand, insofar as social services - in all the countries of the Community - have long dealt primarily with the elderly and with children, their links to employment services became somewhat secondary. This was particularly the case in a country such as Britain, where social assistance - and to some extent therefore social services - was specifically for those outside the labour market.

Nevertheless, it is evident that in recent years these links have been growing stronger. And this seems entirely appropriate. For the family and community networks which it is the task of the social services to support in times of stress include, surely, the networks of the workplace and the training programme. Thus, in France the Revenue Minimum d'Insertion (RMI) requires social service workers to define with claimants a contrat d'insertion and then to monitor its implementation. In the Netherlands, similarly, during 1988 the municipal social services and employment services began cooperating in interviews with the long-term unemployed, designed to produce individual action plans for improved chances of re-insertion. These plans would include work motivation, basic skills, vocational training, job experience and finding and supervision of the action plan can involve both services. Moreover, in the field of employment the municipal social services are now the major executive organisation implementing two government employment schemes: the Job Pools scheme and the Youth Employment Guarantee Act.

These links between the social services and the employment services are not however to be found only in relation to the able-bodied unemployed. They are also apparent in relation to some of the traditionally high priority client groups of the social services. In the Netherlands again, concern has been growing in recent years about the number of people receiving social insurance disability benefits outside the labour force. This concern is driven not so much by advocates of the disabled, but by the social partners, who in Bismarckian systems are strongly represented in the administration of social insurance funds and who (under pressure from the national government) are concerned to limit social expenditure. Policy debates have involved calls for programmes for the occupational re-insertion of disabled people, through counselling and retraining. Here again, attempts at cooperation between the social services and employment agencies are under way (NL:6-7).

Connections between the social services and employment are significant in several other Community countries. In Greece, the social services are commonly taken as including job placement services, including those dealing with immigrants. In Germany, the development of the ASD (General Social Service) in Munich (1978) was intended to provide a holistic approach which would, inter alia, include counselling on employment problems. Clear links are

also evident in the national reports on the Netherlands, France, Italy and Ireland but are much weaker in the case of the UK.

2.5. CONCLUSION

Finally, the relationships between the social services and these other instruments of social policy can be illuminated by reference to indicators of the resources involved.

What weight do the social services have in public spending; and in comparison with other branches of social policy?

PUBLIC EXPENDITURE ON SOCIAL SERVICES

	Year	As % age of GDP	As % age of Public expenditure
DENMARK	1975	6,9 %	
	1980	6,3 %	
	1985	6,1 %	
	1990	6,0 %	
SPAIN	1972	0,24 %	1,04 %
	1980	0,59 %	1,81 %
	1988	0,88 %	2,34 %
UNITED KINGDOM		In England, pss approx 17 % of health/pss (just public expenditure, GJR*)	

DAY-CARE INSTITUTIONS FOR CHILDREN

	Year	Public	Private
GERMANY	1998	16000	18500

Source: Landwehr, 1992

*GJR: If pillarisation was one barrier to coherence, now - under vertical decentralisation - the Belgian system of cooperative federalism, under which each government sphere - national, Community, region - has its own established powers and sphere of responsibility, could presumably make for difficulties in adjustment to new situations. Cf UK supremacy of Parliament and central executive. Cf Table 4 (fourfold expansion of numbers of same private homes).

CHAPTER 3: THE SOCIAL SERVICES AND THEIR EFFECTIVENESS

3.1. INTRODUCTION

This chapter is concerned with specific social services: the rights and entitlements which they offer to citizens; their effectiveness in delivering these entitlements; the barriers to access which users encounter; and the additional measures that have been launched to overcome these barriers and to compensate for their effects. In each case, as well as offering a broad overview of the situation prevailing in the various countries of the Community, we present data on certain very specific minimum services, in an effort to allow a more rigorous cross-national comparison.

We are taking social services as being concerned to support family and community networks which are under stress. These community networks may include networks of occupational participation, not just those of the neighbourhood.

Some social services may be open to the population in general (Section 3.2). Even so, they tend to be used disproportionately by certain population groups; and services may be specifically dedicated to those groups (Section 3.3, 3.4). Some social services, on the other hand, may be concerned less with the needs of individual clients and their families, more with combatting the broader socio-economic processes which place stress on the family and community networks in the localities concerned and which render them vulnerable (Section 3.5).

3.2. SOCIAL SERVICES FOR THE GENERAL POPULATION

In many cases, social services are open to the general population. They include, for example:

* in the Netherlands, generic social work (with associated specialist units): 178 agencies delivering services at 722 bureaux in 1989 and providing a point of first call, which can channel clients to specialist units (private non-profit organisations);

* in Germany, family counselling services (local authority child welfare department, associations of private welfare work) (Landwehr, 1992, p. 24); the same in Greece;

* in Italy, family counselling and therapy centres - usually private, often Catholic, but also in public family clinics;

* in France and Spain, local centres of social services.

These agencies and their voluntary sector counterparts provide a range of services for people in difficulties, which cannot be narrowly identified with any of the population groups to be discussed in subsequent sections.

3.3. SOCIAL SERVICES FOR PARTICULAR POPULATION GROUPS

Even where social services are open to the general population, they are used disproportionately by - and therefore they concentrate upon - certain groups. In many cases, however, services are organised separately and explicitly in terms of these groups. This can produce dangers of labelling and stigmatisation, people with special needs being dealt with separately from the "mainstream". There is least risk of such labelling when there exists a broad infrastructure of mainstream services, into which the integration of needy individuals can eventually be foreseen, but on the basis of which additional support can be given to those with severe needs.

There are some differences among countries as to the main population groups with which the social services are concerned, but these differences are small in comparison with the similarities. The principal groups are the following:

* elderly people
* people with disabilities
* children, young people and women with an insecure domestic situation
* immigrants and ethnic minorities
* people with problems of mental health
* people suffering HIV/AIDS
* people with substance abuse
* homeless people
* low income households faced with social exclusion.

While the list of population groups may be very similar, the priority accorded to each of them appears to vary, to judge by their visibility within our national reports. Some crude comparisons of relative priority are also possible by reference to the welfare effort devoted to these different groups by the social services (Table 2). For the three major groups - the elderly, the disabled, and families - they suggest that the effort devoted to services for the elderly is the most everywhere, but that this superiority is least marked in the case of countries such as Denmark and the UK, most in the case of Belgium, Ireland and Spain. Whether this can be explained in part by reference to the greater importance of public sector social services in the former countries, or some other factors, is beyond the scope of the present study. However, any such attempts of giving an explanation are impeded by the major data gaps and problems of cross-national comparability.

Problems also emerge when seeking to assess the effectiveness of these services. At the very least, this requires data on coverage, for example,

* the number of clients (according to different characteristics) using the different types of service and facility (differentiated according to residential/day care/home care but also, if possible, according to the provider - whether a public, commercial or voluntary organisation),

* the staffing and expenditure ratios for different facilities and services, relative to (a) the numbers of clients and (b) the numbers of the client group concerned within the local population, these data being disaggregated geographically and collected at regular intervals.

These data would, for example, enable the Observatory to examine the geographical variations in provision: and the way that some localities are much worse endowed than others in terms of the services and facilities available. They would allow comparison of the levels of provision for different client groups and changes in these levels over time; and the changing balance between different types of provision. These changes could, albeit only crudely, then be linked to specific policy changes (e.g. the policy of closing residential institutions). They would not make unnecessary a more detailed and rigorous evaluation of the effectiveness and efficiency of specific services, but to hope for this on a comparable basis in the different countries of the Community is probably over-ambitious in the immediate future, even if such evaluations are becoming more common within a few individual member states.

Even these data are not, however, in general available: certainly not on a common cross-national basis, and in many cases not even within individual countries. Nevertheless, as Table 2 illustrates, some data of the sort listed above are already collected on a routine basis, in at least some Community countries. This suggests that improvements in the data available, along the lines suggested above, are by no means impracticable. And the moves which are being made in some countries to improve the planning and monitoring of social care are also encouraging, as are the obligations which are increasingly being placed, on those who implement policy, to monitor and evaluate their efforts. In France, for example, under the auspices of a "conseil national scientifique d'evaluation". It is, however, too early to guess how ready national administrative systems would be to embrace Community-wide definitions of the data to be collected.

Yet of course, it is not with the general effectiveness of the social services that the Observatory is concerned, but rather with their effectiveness in relation to the social rights which citizens are supposed to enjoy and efforts to combat social exclusion. Throughout this chapter, these social rights are at the centre of attention, as will be seen. Their content is commonly ill-defined as a result of: the discretion left to social service professionals, the local variation in provision and the delegation of services to non-statutory bodies. As for social exclusion, there are specific forms to which the social services are commonly addressed: these include social isolation (which may, for example, be caused by disability or the frailty of old age) and confinement (as experienced by those in residential institutions, but also by those who care informally for people with special needs within their own home). These also provide repeated points of reference through this chapter, even if it has not been possible to use them as well-defined - even quantified - indicators of social service effectiveness.

3.3.1. SERVICES FOR ELDERLY PEOPLE

Section 5.2 of our General Report (Room et al, 1992) deals more generally with the risks of social exclusion faced by elderly people and the role of different policy instruments in combatting this risk.

Table 3 provides an overview of use of social services by elderly people (although as can be seen, the data vary greatly).

The ageing of the elderly population during the coming decades means that an increasing number of elderly people will require long-term social care, which in many countries is relatively under-developed. Against this background, much of the recent social policy

TABLE 2: PRIORITY GROUPS IN THE SOCIAL SERVICES

There are several ways in which the relative priority being given to different client/population groups might be defined. This Table illustrates some of the most obvious methods, taking in each case familes, elderly people and disabled people as the main groups.

ia. Inputs: Expenditure

DENMARK Proportion of social services expenditure devoted to specific population groups				
	1975	1980	1985	1990
Families	24%	28%	30%	31%
Elderly People	36%	40%	40%	37%
Disabled People	15%	8%	9%	12 %
	ENGLAND	AND	WALES	
Children				28%
Elderly People				46%
Disabled People				23%
Mentally ill				3%

ib. Inputs: Staff Numbers

DENMARK Proportion of social services expenditure devoted to specific population groups				
	1975	1980	1985	1990
Families	36%	42%	39%	40%
Elderly People	42%	44%	44%	41%
Disabled People	13%	6%	7%	9%

ii. Throughputs: Number of Users

BELGIUM Number of clients assisted by social services for families and elderly people (DGBH) in the Flemish Community			
	1980	1985	1987
Families	18,4%	18,6%	19,1%
Elderly People	76,7%	75,7%	74,6%
Disabled People	4,9%	5,7%	6,3%
TOTAL	100%	100%	100%

IRELAND Number of Clients of home and meals services on 31.12.89				
	HOME HELP		MEALS	
	NUMBER	% AGE	NUMBER	% AGE
Families	1019	7 %	228	2 %
Elderly People	12757	85 %	10539	96 %
Physically Disabled	1159	8 %	227	2 %

SPAIN Number of Clients of Municipal home help in 1990					
	Municipalities 20 000 + inhabitants			Country as a whole	
	1985	1987	1990	1990	
	% AGE	% AGE	% AGE	NUMBER	% AGE
Families	16,8 %	10,5 %	8,8 %	3265	8,0 %
Elderly People	69,3 %	81,3 %	84,1 %	34181	83,9 %
Disabled	12,4 %	6,9 %	5,8 %	2698	6,6 %
Others	1,6 %	1,3 %	1,3 %	584	1,4 %

debate about the care of elderly people has been dominated by "a concern to contract - or at least to limit the growth of - care provided in institutional settings" (Jamieson and Illsley, 1990, page 5). This is in considerable part because of the cost of such institutional care to the public purse; but it is also part of a more general ideological reaction against institutional milieux, as disabling the residents. The alleged consequences for social exclusion are central and three-fold: first, the disabling experience of confinement in an institution; second, the isolation which informal carers may experience, as they bear the growing burden of caring for elderly people at home; third, the problems which may arise in gaining access to ambulant services, which in non-institutional settings can play a most important role in determining the quality of life enjoyed both by the elderly person and by the informal carer.

This is not the place to attempt any broader assessment of these debates. There is a large piece of literature and, indeed, a sister Observatory is concerned with social and economic policies affecting elderly people [5]. This section does no more than indicate some relevant aspects of the social services, as highlighted in the national reports prepared within this Observatory.

[5] See Walker et al, 1991

TABLE 3: OLDER PEOPLE AND THE PERSONAL SOCIAL SERVICES IN THE EC

		% of people aged 75 and above					
	Principal means of access	In residential/ nursing homes	In day care	getting home help	getting meals at home	Geographical variation	Comments
BELGIUM	Public Centres for Social Welfare Voluntary Organisations	NA	NA	NA	NA	Some	
DENMARK	Social Security Office	10,0	12,0	31,0	NA	Some	
FRANCE	CCAS* Health Services General social workers**	9,3	NA	10,0***	NA	Some	* Centre Communal d'Action Sociale ** Assistants Sociaux polyvalents *** Very rough estimate
GERMANY	Welfare Associations Service Centres	3,6	NA	NA	NA	Moderate	* of population aged 65 and above
GREECE	Local branch of National Welfare Organisation	1,4	NA	NA	NA	Very	* Very approximate
IRELAND	Public Health Nurse Community Social Work Office	6,0	NA	8,9	7,3	Very	Population data and provision data relate to different years
ITALY	Health Service Social workers	4,1**	NA	3,1**	NA	Very	** aged 65 and above in Lombardy only (1988)
LUXEMBOURG	Cerpa *	4,0-6,0	NA	NA	NA	Some	*Centre Regional Pour Personnes âgées
NETHERLANDS	Family doctor Direct to particular provider	19,0	NA	14,2	NA	Some	
PORTUGAL	Social Security Centres Health Administration	(26,379* persons)	(22,812* persons)	NA	NA	Very	* Population data not available
SPAIN	Caritas Red Cross Centres of Social Service	NA	NA	0,15-2,3 *	NA	Very	* Aged 60 and above
UNITED KINGDOM	Social Service Departments Family doctor	6,3 *	0,8**	14,7°	3,7°°	Some	* excludes nursing homes ** based on places in day centres (1990) °based on total hours, assumed on average per person of 3 hrs.p.w °°based on total meals, assumed on average per person of 5 meals pw

1. Data relates to 1989/1990 in most instances 2. NA = Not available in country reports / in country 3. Estimate of geographical variation based on individual reports

a. The Reaction Against Institutional Confinement

This is general.

In Denmark, the number of full-time equivalent staff working in nursing homes for the elderly is down to below 90% of its level ten years ago, while the numbers in day care centres, home help and home nursing are, respectively, at levels 225%, 134% and 231% higher. No residential homes for the elderly have been built since 1988 (Ramhoej, 1992, page 16).

Concomitantly, there has been the development of a range of differentiated housing provision, from the nursing home proper to sheltered and "collective" dwellings, and pensioners' apartments within social housing blocks. The same goes for many other Community countries including Germany and France. Temporary entry into residential care, while maintaining a more independent existence for the rest of the time, is becoming common; and in the Netherlands, for example, homes for the elderly have since 1986 been offering short stays for those who normally live at home: this includes pedicure and other attention. The numbers of elderly using this facility rose from 6250 in 1986 to 14400 in 1990.

Of course, one consequence of the reduced resort to institutional provision is that those who remain are, disproportionately, those in the worst physical or mental condition and in a high state of dependency. In Germany, for example, there are therefore efforts to shift the balance within institutional provision from residential to nursing homes. The same shift is occurring in the Netherlands (Pijl, 1992, p. 15). But in some countries - for example Luxembourg - the aim is to blur the distinction between the two, so that once an elderly person has been received into institutional care, no dramatic moves are needed as his or her degree of frailty increases. Generally, the greater degree of dependency of those in institutional care is placing concomitantly greater pressure on staff numbers and skills.

Residential care will remain important for a significant minority among the growing numbers of very old. In some countries, the supply of such care remains very inadequate. Thus in Greece, for example, there are just 20 public nursing homes, with approximately 2000 beds, not all of which are occupied by elderly persons, and just 2 public residential homes for the elderly, with less than 100 residents. Conditions in these homes frequently lead to a deterioration in residents' capacities and there is evidence that approximately 30-50% of residents become bed-ridden within a few years of entry. However, the Church and other non-profit private organisations have operated numerous residential institutions for the elderly in recent decades - much more significant than the public sector - and during the 1980s the commercial sector also grew in importance.

b. Support to Informal Carers

Despite the shift to non-residential care, demand for institutional care continues in some countries to exceed the supply. In Luxembourg, during recent years there has been a dramatic lengthening in the queues of people awaiting entry to nursing homes: even those in greatest need of admission currently have a two-year wait. It is partly in response to this crisis that care allowances have been introduced in some countries, to support care in the home, albeit with conditions on income and degree of invalidity.

Informal carers need not be the kin of the elderly person. One recent development in Spain has been the promotion of "foster familes" for elderly people, financed by the public authorities (Casado, 1992, p. 11); the same is being developed in a few municipalities in Italy (and also for the disabled), and under recent legislation in France. However, dependence on informal care can, of course, involve considerable strain on both sides. The burden of care falls primarily on women (cf Section 4.8 below) and may, moreover, constrain their own economic independence and occupational insertion.

In Ireland, a study by the National Council for the Elderly (1988) estimated that the number of elderly people receiving a significant amount of care at home is more than three and a half times the number of elderly people in institutional care. The same goes for large numbers of people with disabilities. But these informal carers are confined to the house for long periods: three quarters for more than five hours a day. They are prevented from participating in social activities, not least in the evenings; and they cannot take holidays. Exclusion is thus a risk for carers, as well as for elderly and disabled people themselves, unless respite care can be greatly expanded. More respite care is available for people with disabilities, but it is very unevenly distributed.

c. Access to Ambulant Social Services

In most countries of the Community, efforts are being made to develop ambulant services, capable of keeping people in their homes, in an effort to moderate the growing demand for residential care. These at-home care services, a substitute for institutional care, should not of course be seen also as a substitute for family care but as a necessary supplement to care provided by the family. Such services can considerably lighten the burden of informal care and enhance the willingness of families to provide it.

Home help services - involving very practical, low skilled help - are an obvious element of ambulant provision and are adopted in all member states, in principle at least. Thus in Greece, for example, the programme of Open Care Centres for Older People (KAPI), operated by the local authorities and funded and supervised by central government, aims at providing various ambulant services including home help. However, as yet only 6% of the elderly population have access to such centres, and very few of the latter as yet provide home help, because of inadequate staffing and funding. These and other social services are also provided - but on a very limited basis at this stage - by voluntary organisations such as the Greek Red Cross (within specific areas of the capital, Athens) and by the National Welfare Organisation (in one urban and one rural community).

In Spain, since 1985 home help has developed strongly, particularly in urban areas, under municipal sponsorship (NGOs being active in referring clients): especially in the Basque Country and in Murcia, in such cities as Madrid, Barcelona and Valencia and in the Canaries. It is mainly targetted on elderly persons. This help is mostly provided by the municipality directly, with very little contracting-out of services to private contractors. Nevertheless, even in those areas where the services are most developed, only 1 in 40 elderly persons is receiving such help, compared to 8% foreseen in the National Gerontological Plan.

In Denmark, research evidence suggests that levels of "consumer" satisfaction are in general high: comparable evidence from other countries is not available. Research evidence

from Germany indicates that home help does indeed enable elderly people to remain living independently in their own homes. However, this is clearly affected by a number of other factors also: the dwelling itself, the network of neighbourhood contacts, other social services in the area, etc.

Day centres are important in supporting social networks and stimulating self-help and mutual aid, but also in providing therapy. In Greece, the above-mentioned Open Care Centres are day centres offering a range of health and social services. These have been a significant development of the Greek social services, even if much remains to be done. In Denmark, approximately four fifths of such day centres are municipal. However, only approximately 7% of elderly people use them (more in urban areas). Nevertheless, these users are disproportionately concentrated among the very old and those who live alone, which may be taken as indicating that the centres do indeed serve a function in supporting social networks for those who would otherwise lack them. In Germany, Service Centres for the Elderly - a relatively new type of service for Germany, are similar, in providing counselling and social contacts and mediating ambulant aid.

More generally, in many countries voluntary organisations have been playing a growing role in promoting neighbourhood support networks, with the support of public subsidies. These are of importance, not least, in reducing some of the problems of isolation which elderly people commonly face. In Ireland, for example, surveys have shown that loneliness is a major problem among the latter: voluntary organisations play an important role in creating and maintaining networks but they are geographically very uneven.

Nevertheless, there are significant barriers in gaining access to these ambulant services. First, in most Community countries very limited public funds are allocated to their development. Their coverage of the population is therefore very limited, despite the high levels of social expenditure taken by the elderly, which should create incentives to develop more cost-effective solutions, as against traditional institutional provision. Second, in most countries there is a major lack of trained staff. Finally, in many cases, there is a very uneven geographical distribution of these more innovatory services.

Having highlighted these three elements of change in policy towards elderly people, it is important to ask: how are these policies affected by the varied and changing divisions of responsibility which were the subject of Chapter 2? Do the cross-national differences in social service regimes which were surveyed in that chapter produce differing patterns of social exclusion for the elderly and their carers? The materials available to us for the present study are insufficient to justify any substantial attempt at answering these questions here, but they can stand as an agenda for any follow-up research [6].

In Germany, the private "confessional" welfare organisations are the principal providers of residential care; places in residential institutions numbered 335,200 in 1990. However, in the 1980s commercial organisations discovered the elderly: and posed a threat to the traditional monopoly of the confessional organisations (affording the latter substantial public subsidies). In France similarly, recent years have seen a considerable growth in

[6] These and similar questions are of course already addressed in some other cross-national research studies: see, for example, Jamieson and Illsley, 1990.

commercial residential care, targetted on the more affluent elderly. This seems likely to accelerate with the decentralisation of the public authorities, inasmuch as city authorities are now tending increasingly to engage private providers of services through formal contracts, as has already happened in other fields of municipal activity.

In Germany at least, this expansion of commercial care seems likely to be to the detriment of low income groups in particular, who are excluded from this new commercial sector of care by the prices charged. (In the UK similarly, where there has been an expansion of commercial residential care, there are fears that private accommodation will take only fit, relatively able customers, leaving severly disabled or senile people to state provision.) On the other hand, the supply of care is increased and in Germany at least, there are hopes that the high quality of some of these new providers may serve to stimulate the quality of the public sector also.

The Box presents the minimum services normally available to a frail and very elderly person in the various countries of the Community [7]

3.3.2. PEOPLE WITH DISABILITIES

People with disabilities are at considerable risk of becoming socially excluded: in part because of inadequacies in social care services, in part because of barriers to labour market participation. Section 5.3 of our General Report (1992) dealt more generally with these risks and the role of different policy instruments in combatting them.

The HELIOS network of the European Commission is promoting improved comparability of data in this field. However, detailed information about people with disabilities, and the opportunities which they enjoy, varies greatly between EC countries. In the UK, the first national surveys since 1968/9 were undertaken in 1984 and published in 1988. In Ireland, there is little centralised information: even the local registers of people with disabilities are incomplete and lack any standard system of classification. In Greece, 1991 saw the launch of a new census of the disabled, but the results will not be available before the end of 1992.

The definition of disability is more complicated than that of (old-) age; and the degree of handicap, as officially recognised, will determine entitlement to different services. In

[7] The Boxes refer to the services which are available, but they exclude financial benefits. However, this is in some ways an unsatisfactory exclusion and it can be justified only for this very crude and provisional overview of services in different countries. For example, supplementary cash benefits which are paid to some of the client groups listed here, in order that they can purchase additional care and aids to living, are excluded from the tables; whereas similar aids purchased and supplied by the social services themselves are included. Also excluded are a range of other cash subsidies, taking the form of reduced or zero-price access to public transport, fuel, etc. (see also, however, the 1992 General Report of the Observatory, Room et al 1992, Box 9, which deals with these benefits).
Some of the services included in the boxes are provided free of charge; others may requirement payment, according to the income of the recipient; others, again, may be restricted to those who are receiving social assistance/minimum income support. However, they represent the services that are normally available as a minimum to a person having the characteristics indicated.

Germany, for example, the level of handicap must be recognised as at least 50% if the person is to qualify for additional services under the Law for the Severely Handicapped (Landwehr, 1992, p. 27). So also, the status accorded to different disabilities within public policy varies in Italy, for example, the blind have a more consolidated system of provisions than, for example, victims of Downs syndrome.

TABLE: MINIMUM SERVICES: CASE 1 [8]

A vey old person (85 +), living alone and receiving a minimum pension only: difficulty with activities of daily living because of physical impairment.

COUNTRY	SERVICES AVAILABLE	
BELGIUM	Services available through local CPSW (Centre for Public Welfare): Voluntary organisations (linked to pillars):	Home help, meals Disability aids Recreational activities
DENMARK	Public services: Private services:	Home help free of charge (1988: 61% of people aged 85+ received) Home nursing free of charge Disability aids and adaptations to dwelling Meals and preventive health care Operate as supplement to public services and with their support: includes day centres. Vary regionally much more than public services
GERMANY	Municipal and private welfare agencies: Service centres for elderly: Commercial agencies	Meals and home help Some sheltered and group housing Counselling, ambulant aid, social contacts Targetted on more affluent elderly
GREECE	No entitlements to at-home services. In a few areas, such services are procided by Red Cross, National Welfare Organisation, etc (State-funded), but these affect less than 1 % of elderly population.	
SPAIN	Entitled to home help:	service is more developed in urban areas

[8] In Denmark, special day centres for extensively disabled children who have special needs for pedagogic support and treatment; sheltered dwellings for extensively disabled adults, attached to institutions but also incorporating sheltered workshops; communal dwellings for those of the extensively disabled who are most able to cope independently; psychiatric units helping the users to integrate into local networks, leisure activities, etc, and bringing tohgether actions by the hospitals, the social services and self-help groupes;
In Italy, after the closing down of psychiatric hospitals, an alternative is being developed for the young and adult mentally ill, mostly in the centre and north, through the creation of day hospitals and protected small communities. The former are still in an experimental stage (although in Liguria and in Lombardy, for example, a few centres are already fully functioning).

COUNTRY	SERVICES AVAILABLE	
FRANCE	Free health care; 30 hours of home help per month, or subsidy to use some third person (financed by Aide Sociale); home nursing care (financed by Health Insurance Funds)	
IRELAND	Formal Entitlements:	Health Service and Medical Card granting free treatment Public health nurse
	Eligible for Additional Services, but great variation between areas:	Disability aids and adaptations to house if agency budget permits Chiropody service Local authority or sheltered housing may be available, but low supply Home help service and meals
	Voluntary organisations:	Day care centres
ITALY	Eligible for local authority housing Disability aids and adaptations to dwelling. In some regions:	home nursing
	Law provides for home help in all regions:	but implementation is left to municipalities and their budgets. In south and in economically marginalised mountain areas of centre/north, many localities where none.
	Self-help groups/volunteers: supplementary services	
LUXEMBOURG	Home help, nursing care, meals-on-wheels, tele-alarm (in certain areas)	
NETHERLANDS	Home help District nurse Adaptations to dwelling Meals on wheels Short stays available in residential homes Recreational centres	
PORTUGAL	Home help:	but only available in some districts
	Day Centres	
UNITED KINGDOM	Main Services offered within framework of:	National Health Service: Family doctor Community Care Plan of Local Authority Social Services (in future)
	Specific Services:	Offer of meals-on-wheels and home help Disability aids and adaptations to house if budget permits Possibly: transport to day centre; and short-term residential care.

In some countries - for example Spain - the development of specific national policies in relation to people with disabilities is only recent. Elsewhere, existing laws are being reformulated and made more coherent. In Italy for example, January 1992 saw a new Framework Law approved, unifying all previously existing laws concerning the rights of the handicapped and the obligations of the public authorities towards them. Regions must now

establish their own implementing laws and regulations. The Framework Law defines the rights of people with disabilities in relation to health care from birth; social integration (by home helps, elimination of architectural barriers, transport); schooling (hence schools must be ready and teachers trained); vocational training and job insertion; sport and leisure; and housing (a quota of public housing). It also provides support to those caring for disabled people: supplementation of any social pension which the carer is receiving (but therefore benefitting only carers with low incomes); rights of job security if employment is suspended in order to undertake caring; and credits towards pensions for such absent periods. But these latter rights apply only to those in permanent full-time work: the privileged "core" workers.

a. Institutional Provision

Institutional provision remains important in most countries of the Community. As in the case of elderly people, the drive to reduce the use of institutional care has not removed the need for some institutional provision for those having the most severe physical and, especially, mental disabilities; and to offer temporary respite care for those normally living at home. These remaining institutions must offer more specialised nursing care, since the residents who remain have more severe needs; and indeed, in Denmark for example, recent years have seen an increase in the number of special nursing homes of this sort, with high staff:resident ratios.

Intermediate between full institutional care and ambulant services are a range of day care centres and sheltered dwellings, for example:

b. Access to Ambulant Services

As with the elderly, people with disabilities may have have access to home help and home nursing services and they may be eligible for adaptations to their dwellings, along with other technical aids, which in many countries if available are supplied free of charge.

However, there are significant limitations in the support which these ambulant services provide. Italy is not atypical. In many cases, the geographical distribution of services is very uneven; for example, Downs syndrome children are now routinely enrolled in normal elementary schools in the centre and north of Italy, but only exceptionally in the south. There are major gaps left by the different public services: thus, for example, the family of a handicapped young person, old enough to have lost entitlement to educational provision but not sufficiently handicapped to be accepted into a special centre, receives very little in terms of support to social integration. Finally, in many countries (including Italy and Germany) where public social services are still very much connected to the social assistance tradition, public policy stresses the role of the family, as against institutional care, but in practice support is concentrated on those who are on low incomes, rather than being provided on a more universalist basis.

c. Vocational Training and Rehabilitation

As with elderly people, much of the recent social policy debate has been dominated by efforts to reduce reliance on institutional care, in favour of ambulant services. In addition,

however, the aim of enabling people with disabilities to lead as normal a life as possible means that vocational training and rehabilitation and support to employment are also important in combatting social exclusion.

Two examples may suffice. In Denmark, the county authorities are obliged to provide vocational rehabilitation, assessment of working capacity and retraining. There are sheltered workshops for disabled people unable to retain normal employment. In Greece since the 1980s, the Manpower Employment Organisation (Ministry of Labour) has been centrally involved in new programmes of vocational training and job placement for people with disabilities, aiming specifically at their social integration. The National Foundation for Rehabilitation of the Disabled offers vocational training programmes and work centres. Not surprisingly, the flow from the Foundation into the open labour market is rather limited, in part because of the mismatch between vocational training programmes and labour market needs; but in an effort to surmount this, the Foundation cooperates with the Manpower Employment Organisation to promote job placements.

3.3.3. SERVICES FOR CHILDREN

Section 5.4 of our General Report (Room et al, 1992) deals more generally with the risks of social exclusion faced by young people and the role of different policy instruments in combatting this risk; Section 5.5 deals similarly with women.

In countries as different as the UK and Greece, major changes are under way in the public care of children. In the UK, the Children Act of 1989, placing new responsibilities on local authority social servicesdepartments, aims to reduce the need for children to be taken out of their families and into local authority care or to be brought before the courts. Children in lower income households have been at particular risk of being dealt with in these ways. In Greece, until recently many of the children residing in institutions were members of large families whose parents could not support them. Now, however, adoption law reform and the introduction of fostering (until recently unknown in Greece) promises to change the situation substantially, along with recent increases in non-means-tested family allowances, which reduce the poverty of large families and the risk that children will be placed in care.

MINIMUM SERVICES: CASE 2

Downs Syndrome child aged 12, living at home

COUNTRY	SERVICES AVAILABLE	
BELGIUM	Special Education	
DENMARK	Special Education at normal school or in special school	
GREECE	Financial allowance only; no services	
SPAIN	Medical-functional rehabilitation, offered in part through NGOs (with State subsidies)	
FRANCE	Various financial allowances/exemptions	
IRELAND	Special Education (in normal school or special school)	Assessment of special educational needs by psychologist: but provisions offered depend on local education budget and facilities
	School Medical Service	Only 20 % of all children examined under this scheme
	Voluntary organisations	Day care centres train in personal skills: but very uneven distribution Voluntary organisations and health boards may provide respite care to relieve parents
ITALY	Health and social services	Depending on handicap, access to normal school or municipal education centres
LUXEMBOURG	Special education provisions, at a regional centre (transport provided)	
THE NETHERLANDS	Special education (normal or special school) or day care centre	
	Social Pedagogic Service: advice and mediation with other services	
	Respite care of child in institution/hostel	
	Home help and district nursing	
PORTUGAL	Home help	
	Special education	
UNITED KINGDOM	Special Education (in normal school or special school)	"Statement" of special educational needs by Educational Psychologist: but provisions offered depend on local budget and facilities
	Social Services	May provide respite care

The social services typically play a three-fold role in relation to children. Firstly, supervising the way in which parents, or those in loco parentis, exercise their responsibilities and intervening where appropriate. Secondly, providing an alternative to the normal domestic environment, whether fostering or residential care. Thirdly, providing and/or regulating child care facilities, intended to enable parents to combine parenting with labour force participation.

Each of these can have consequences for social rights and exclusion. Supervision of parenting involves the public authorities in taking a position, which may of course be contested and may change over time, as to the rights and responsibilities of the parents and the social rights of the child. The development of alternative, residential, milieux raises the same risks of disabling institutions as have already been noted in the case of elderly and disabled people. The provision of child care may mean that parents are less likely to suffer exclusion from the labour market.

a. Supervision of Parenting

The family is the arena of privacy par excellence. But nowhere in the Community is the welfare of children deemed an entirely private matter, children do have social rights which the public authorities have a responsibility to enforce. Thus, for example, in Germany, notwithstanding the very limited role which the Federal authorities generally play in defining the role of the social services (under the principle of subsidiarity), it is specifically in relation to child welfare that new Federal laws (1991) establish specific legal norms and obligations which are binding on the child welfare departments of the municipalities (Landwehr, 1992, pp. 13-16).

The social services face the dilemma as to the extent and form of intervention in the family which they should undertake, having regard to parents' responsibilities and children's welfare. In Ireland, the 1980 Task Force on Child Services advanced the principle of minimum intervention, with children being removed from their families only in the last resort. But the Task Force, and other reports, have also drawn attention to the dearth of family support services, geared to enabling families to cope better and to place children less at risk. In Germany, the 1970s saw a move away from punitive conceptions of child abuse; there are now, therefore, no child abuse registers, nor any mandatory reporting laws. Instead, child protection centres invite voluntary participation by parents who acknowledge their need for counselling and support (Landwehr, 1992, p. 2x). In some countries, however, for example the UK, something akin to panic has developed over cases of child abuse by their parents and the contradictory demands placed on the social services. High staff turnover, unfilled vacancies and low morale are some of the consequences.

There is, of course, another, but no less important policy concern for young people: that of young offenders. The extent to which this is integrated with welfare policies for children and young people varies, even if the penal elements have in recent decades become generally subordinate to the educative. Thus, for example, recent years have seen substantial reforms of Spanish policy for child protection, with a move away from large residential institutions towards smaller units and fostering arrangements; until 1992, however, policy on young offenders changed little, continuing to be regulated by a 1948 law that contradicted the social rights of the 1978 Constitution.

b. Alternatives to the Normal Domestic Environment

In Greece, children's residential institutions are operated by central government, the (non-governmental) National Welfare Organisation, the Church and various philanthropic organisations. These offer a total of more than 3000 places, which seem to be sufficient;

indeed, the numbers of children entering these institutions has fallen markedly during recent years. However, many of these children are from impoverished families, families with large numbers of children, familes with disabled members, etc, who appear voluntarily to have sought institutional provision because of their inability to cope. This therefore reflects more general deficits in social policy, rather than children being forcefully removed from their homes.

In Ireland, the numbers of children in care are substantially lower than in the 1960s and among them, a lower percentage are in residential care, as distinct from foster homes. In Italy, group housing for children in care is common, with the children attending normal schools. This group housing is normally run by social cooperatives with funding and under contract to the municipality: it serves as an alternative to institutionalisation, but is now declining in favour of fostering.

Indeed, fostering is growing generally as an alternative to institutionalisation. In Greece, a legal framework for fostering is now being prepared.for the first time and better selection and training of foster parents is envisaged. However, it is proving especially difficult to find foster parents for children with handicaps. Fostering is also growing in Italy, but with insufficient available foster families. Here too, however, there are major regional differences: in the South and the north-east, the law on fostering is largely ignored: the authorities prefer to send children to small communities or institutions and in the regions where there are families who are willing to foster, then there is no economic support or counselling.

In the UK as elsewhere, children who are in the care of the local authority social services are drawn disproportionately from the lower social groups. Approximately one fifth are in residential institutions, but the proportion is substantially higher for adolescents and older children, reflecting the greater difficulty of finding foster families for them. Recent scandals have forced a re-examination of the role of these homes, not least, in terms of their success in easing the transition from adolescence to adulthood for these young people. Among the staff, at least, there seems little confidence that they are equipping these youngsters to make subsequent transitions successfully and thereby to avoid later social and occupational exclusion. Nevertheless, the Children Act of 1989 requires local authorities to plan for, and train, young people to leave their care and to become integrated into normal independent living. To this end, local authorities are now required to provide after-care to any young people ceasing to be looked after by them and to coordinate help from local housing, education and health authorities.

c. Child Care and the Labour Market

The extent of public child care varies greatly among the countries of the Community. In Denmark, the majority of pre-school children - more than 60%, albeit with regional variations - use such facilities (but cf. the comparative figures in Table 4). But in offering such care, it is for the individual municipality to decide how far to contract with private institutions and private families to provide places and how far to provide them directly itself. The same local discretion exists in regards to pricing policy, although in general, prices have risen relative to disposable incomes during recent years.

TABLE 4: PROPORTION OF CHILDREN AGED LESS THAN 3 YEARS WHO ARE IN CHILD CARE FUNDED BY THE PUBLIC AUTHORITIES

COUNTRY	YEAR	% AGE
BELGIUM	1988	20 %
DENMARK	1989	48 %
FRANCE	1988	20 %
GERMANY	1986/87	3%
ITALY	1986	5,3 %
LUXEMBOURG	1989	1-2 %
NETHERLANDS	1986	1,5 %

Source: P Moss (1990), page 13; Observatory National Reports

In contrast, in Germany, for example, there is a much smaller supply of such care, even for kindergarten (ages 3-6), with more limited public subsidies and higher charges on parents. However, regional variations are substantial, as between the northern Länder and Bavaria, for example. The same goes for France, where public creches vary from more than 42 per thousand population in Ile-de-France to less than 7 in Brittany and Picardy.

Nevertheless, even in Denmark there is much unmet demand for pre-school places. If parents cannot get child care, many mothers are at risk of giving up their jobs; without child care, they are not available for work and hence cannot claim unemployment benefit. The same problem arises, more intensively, elsewhere, and affects lone parents in particular. In France, notwithstanding the traditional importance of its natalist policies, the need for places can (by reference to the employment rates of parents) be estimated between 750,000 and 1 million, compared with perhaps 200,000 places currently available, a gap that has long persisted.

In Greece, similarly, there is a very substantial excess of demand for pre-school child care. Home-based registered "child-minders" are unknown but legislative provision for this form of care is currently under study by policy-makers. Yet of course, official registration and regulation can in some cases reduce the supply of child care available. In Luxembourg, "open door day centres" have been important in offering informal child care in poorer areas, but national conventions (regulations) have in recent years forced limits on the numbers of children who can be received (relative to staffing levels) and have imposed the obligation for children to be registered, to some extent restricting the supply of an important informal service.

In some cases access to creches and kindergartens, where waiting lists are long, may involve priority being given to certain groups: lone parents, low income households, placements by the courts, children at risk of abuse, in Luxembourg for example. This can, however, stigmatise such child care facilities, which come to be seen, however unjustifiably, as a dumping ground for "problem" children. On the other hand, in Denmark, day care places for children tend now to be given more to employed than to unemployed parents, as a result of recent changes in the administrative rules on unemployed and allocation of day care places. The segregation and exclusion of the unemployed and their families are thereby only reinforced.

It would, of course, be interesting to investigate what degree of consistency exists among the different elements of policy on child welfare, as far as subsidiarity and the roles of the family and the municipality are concerned. Where the emphasis on the subsidiary role of the public authorities vis-à-vis the family is weaker, does it then follow not only that public supervision of parenting and of children at risk of abuse is stronger, but also that child day care facilities are more widespread? In other words, does the extent of parental regulation by the public authorities correlate with the extent of public provision to support parents, to enable them to raise their children without difficulty and to fulfil their "contractual" obligations to society? However, these questions are beyond the scope of the present study.

3.3.4. REFUGEES AND MIGRANTS

Refugees face asylum laws which may involve waiting for several years. In some cases, these laws are becoming more restrictive in face of the large number of applications which some Member States, notably Germany, have been facing in recent years. In the UK, with substantial increases in the numbers of people seeking asylum (44000 in 1991, compared with 22000 in 1990 and 4000 in 1988), new measures to control asylum have been introduced by the government and new controls on fraud have been proposed. In Belgium too, there have been significant changes in the law on nationality. From 1992 onwards, third generation immigrants receive Belgian citizenship automatically, as do the children of mixed (Belgian-foreigner) marriages. This will in turn confer political rights; at present immigrants are excluded even from local elections. However, a new Immigration Act (1991), as well as simplifying procedures, establishes additional restrictions on entry of refugees from Ghana, India, Pakistan and Poland and has produced a reduction in the numbers of refugees accepted.

During the waiting period, specific support services are normally made available, not so much to integrate the asylum seekers into the host society as to sustain them in their highly provisional status. Thus, for example, asylum seekers are normally not allowed full rights of mobility. In Denmark, they are placed in asylum centres, in the care of the Ministry of Justice and the Red Cross. In Germany, they are assigned to specific Länder, where they are lodged in special dormitories under the responsibility of the local authorities, and cared for primarily by the private welfare associations. In Belgium, the local CPAS (Public Social Welfare Centres) are required to provide residential accommodation to refugees but not all have done so. The larger cities in particular have refused to take new refugees, because of the large numbers already there and their fears of both the financial burden and the social tensions.

Migration from eastern Europe and the CIS

Particularly noteworthy are the arrangements which have been developed in some Community countries since the beginning of the 1990s to receive compatriots from eastern Europe and the CIS. The settlement and social integration of these people is no easy task and is placing a serious strain on the social and other services of the principal host countries.

Pontians in the former Soviet Union are estimated between 600,000 and 800,000; those returning to Greece numbered approximately 14000 in 1990, an annual flow expected to increase to 20,000. (The Greek minority in Albania exceeds 400,000 and constitutes a second major source of likely immigration: but it seems likely that this will take the form of seasonal

cross-border mobility, rather than permanent immigration). These people, mostly young adults, tend to be concentrated into northern Athens and Thessalonika, in overcrowded housing and suffering high unemployment (>50%). Social exclusion tends to arise from language barriers and the immigrants' lack of informal social networks. Successful settlement and integration of these people is likely to be the major single challenge for Greek social policy in the 1990s.

In Greece, new arrivals are able to stay at reception centres for two weeks, receiving accommodation, social assistance and advice on employment and housing. However, in face of the persisting problems of integration faced by the newcomers, the Ministry of Foreign Affairs has established a new agency, EIYAPOE, for the reception and integration of foreign Greeks offering: language support, vocational training, housing in reception villages where they can stay for up to a year - and subsidised employment. However, it seems likely that they will then drift to the main urban centres, unless economic development takes place within some of the less developed parts of Greece, offering more widespread of opportunities.

One key factor in their social integration is the availability of informal networks of Pontian Greeks, including local cultural societies, professional associations and national federations. This also affects the speed with which the families of those household heads who arrive first in Greece will be able to follow. And finally, therefore, it also shapes the task faced by the social services, in their efforts to support family and local community networks which are under stress.

Nor are refugees during this waiting period normally allowed to take employment or have access to the education system. But this depends in part on the length of time normally involved in decisions on applications for asylum. In Germany, for example, where it can take years (compared with three months in Denmark, for example), permission has in recent years been given for refugees to work after one year (Landwehr, 1992, p. 38).

Once asylum has been granted, certain additional services are often available to support integration into the host society. The Danish Refugee Council carries out a programme of reception and integration normally lasting 18 months and involving linguistic and vocational training. Evaluation of this programme with respect to the subsequent insertion of refugees into Danish society suggests success in linguistic and educational terms, but not in terms of employment integration. In Ireland, the Refugee Agency organises language training, but only for refugees who arrive under agreements sponsored by the Irish Government; other refugees - only a few in number - can turn to services provided by the Red Cross, for example.

Section 5.6 of our General Report (Room et al, 1992) deals more generally with the risks of social exclusion faced by migrants and ethnic minorities and the role of different policy instruments in combatting this risk. As noted there, migrant workers and their families within the EC countries enjoy rights, or suffer from a lack of rights, depending primarily upon their nationality. EC nationals will, increasingly, enjoy the same formal rights as citizens of the host country; legal immigrants from outside the EC have more restricted rights; clandestine immigrants have fewest. Corresponding to this gradation of rights, such migrants and their families will be, and are, exposed to multiple insecurity, not least in respect of access to the social services, even if their social needs are substantial and their risks of social exclusion serious.

Legal immigrants are normally eligible for social assistance and for the local social services. Nevertheless, there can be major limitations on this eligibility. In Luxembourg, for example, despite a long history of immigrant labour and the present high proportion of foreigners in the population (more than a quarter), stringent residence conditions limit eligibility for the RMG (minimum guaranteed income) and its related services. In Italy, children have access to day care centres and kindergartens only if there is a formal residence certificate. Other educational provisions are more flexible, however, in allowing access even by children with only a tourist visa, especially in the centre and north of the country. As for health care, immigrants with a visa can use the same general health services as Italian citizens; but without a visa they are obliged to resort to the emergency wards of hospitals. Spain, too, has become a major point of entry for clandestine immigrants and faces many of the same dilemmas of public policy.

Studies in Flanders reveal other, practical barriers which migrants face in gaining access to social services (although these studies are based on the experience of social workers, not of migrants themselves. Among the barriers to effective communication which institutional regulations have erected are those of employment law: most public social services may employ people only of Belgian nationality or increasingly EC nationalities, but not migrants' own nationalities. Nevertheless, some new efforts at integration are also in evidence in Flanders, with intercultural workers being appointed to improve communication between health workers and ethnic minorities.

3.3.5. SERVICES FOR OTHER HIGH RISK GROUPS

a. Victims of AIDS/HIV

Victims of HIV/AIDS pose a major new challenge for social care services as well as health care, a challenge that is only reinforced by the social stigma attaching to these conditions.

CASE 3: COUPLE WITH TWO SCHOOL-AGE CHILDREN, RECENTLY ARRIVED FROM A NON EC COUNTRY AND LACKING LINGUISTIC AND VOCATIONAL SKILLS AND ACCOMMODATION

COUNTRY	Minimum Services Available	
BELGIUM	Refugees:	Housed in transition homes/reception centres for approximately 8 months while case being considered. Then a further 4-5 years investigation can call for aid from centres for public welfare (CPAS/OCMW) (financial assistance and help in finding accomodation). Access to education system for children; linguistic training for adults but waiting list. Municipalities vary greatly in services offered. NGOs offer services to refugees, esp Red Cross.
	Immigrants	An immigration stop in Belgium: so recent entrants either refugees or illegal.
DENMARK	Refugees:	Care by Danish Refugee Council for 18 months: help to find accomodation + linguistic training + help to find work (difficult) + help with access to benefits and services (same conditions as Danish citizens). Thereafter no special services.
GREECE	In general, no special services offered. However, Greeks arriving from eastern Europe/CIS benefit from a range of services designed to assist their integration into Greek society: not only financial support, but also temporary accommodation, language courses, health care, vocational training, subsidised employment. Cultural associations link new arrivals with Pontian communities, etc.	
SPAIN	Refugees:	Supported by Red Cross (with State funds) for six months
	Illegal immigrants:	Receive some sporadic aid from NGOs. Access to housing in particular is difficult for new arrivals.

COUNTRY	Minimum Services Available	
FRANCE	Refugees:	While applying for asylum, can apply for entry to a reception centre; or-if no places-can receive a financial benefit. Children have access to schools. Adults cannot take employment or vocational training. Once refugee status has been granted, they can enter a centre for new arrivals
IRELAND	Refugees.	No special educational provisions for children: enjoy same rights as Irish. Applicants for refugee status accommodated by Red Cross and then eligible for local authority housing Refugee Agency (Government-funded) provides induction
ITALY	Legal immigrants:	Can be helped only by voluntary organisations: only children may be a concern of public authorities (education etc): in some cities of Centre/North, social workers treat children without legally parents as "abandonned"
	At least one parent legal:	Minimum services: free health care, emergency housing, language training, vocational training
LUXEMBOURG	Very few services available. Some language training for adults and induction classes for children within normal schools.	
NETHERLANDS	Refugees and asylum seekers:	Refugee centres for initial care on arrival. Few measures to assist integration into Dutch society while request is being considered. Association for Working with Immigrants: organises language courses, recreation, etc. Therafter, more suitable accommodation sought (efforts by government to spread more evenly among municipalities), while application for asylum considered (takes several years): at government expense. Local Government must offer similar services as refugee centres, but discretion as to how. 1987-1991: Nearly half of the persons consulting Citizens Advice Bureaux were immigrants: aim to enable people to implement their social rights.

COUNTRY	Minimum Services Available	
PORTUGAL	Regional Social Security Centres, in conjunction with Ministry of Education, offer economic support, housing, school and vocational training to people arrived from Timor. Similar actions exist for refugees, in conjunction with United Nations High Commission for Refugees.	
UNITED KINGDOM	National health Service Education system No mandatory social services, but future Community Care Plan of Local Authority could include social work/child day care. Voluntary sector support, including minority organisations.	Employment advice from statutory agencies. In some local authorities, temporary accommodation Urban Programme grants in some local authorities: social and training facilities for minorities.

Self-help projects of victims have been important in generating new initiatives by the public and private social services. In Germany, for example, around 250 such groups are active in care, counselling and public relations (Landwehr, 1992, p. 32). 90% of their funds now come from public sources.

b. Drug Abusers

In Germany, recent years have seen the development of services aimed at prevention, counselling and therapy, especially in the big cities. In some cities, Commissioners for Drugs have been appointed. A substantial amount of work here, as in other areas of social services, is performed by the private welfare organisations. In addition, there are perhaps 2000 self-help groups (Landwehr, 1992, p. 30).

In the Netherlands, Counselling Centres for Alcohol and Drug Addiction - involving 19 centres and 90 offices - assist users and their families with counselling and resettlement, funded by national government. The municipalities and other social services also run programmes of their own. However, 1990 saw the merging of government funding of these various initiatives, with municipalities now charged with developing drug programmes at a regional level. These will finally form part of the Social Renewal Programme (cf Section 3.2 above and Pijl, 1992, pp. 21-22).

In Italy, there is a prevalence of private agencies, albeit under contract to municipalities, mobilising the work of many volunteers. Most services dealing with drug addicts also deal with alcoholics, homeless people, mentally ill, etc. If they seek therapy, drug users are treated as "persons in difficulty" and therefore often (especially in the centre and north of the country) they receive social minimum benefit; the fee for treatment in a therapeutic community is paid by the health service.

In Spain, the National Plan on Drugs (1985) developed a wide-scale network of health services, concerned principally with illegal drugs but also with alcohol. These seem to attract

those users whose prognosis is better, while those in greater difficulty are taken on by Church-affiliated agencies. This Plan enabled an assembly of NGOs to be established, concerned with care, resource mobilisation and public relations; however, these initiatives sit alongside the criminalisation of drugs and their consumers, sustained by fears of public safety in urban areas which direct hostility against drug users.

c. Homeless

In many countries, local authorities and voluntary organisations run emergency shelters for people who would otherwise sleep on the streets (Landwehr, 1992, p. 33).

In Denmark, to provide such shelters is, indeed, a legal obligation placed on local authorities. In addition to short-stay shelters, there are reception shelters which can also offer medical care and treatment for alcohol and drug abuse. There are also crisis centres for women and their children, who have left home as a result of domestic abuse. And some families are placed in private hotels or bed and breakfast accommodation at the expense of the local authorty.

However, here, as with drug abusers, the penal law plays a role as well as welfare legislation. In Belgium, for example, single men living on the streets may be faced with the punitive treatment demanded by the vagrancy laws; or they may be offered accommodation in reception centres, under the social welfare legislation. And the homeless, having no fixed residence, cannot receive subsistence income.

In France, the Centres for Shelter and Social Readjustment (CHRS), operating under the social assistance law of 1954 but with their role widened by that of 1974, provide a range of different types of temporary accommodation for ex-offenders, vagrants and those who have left residential institutions but who lack any accommodation, and (since 1974) even whole families. Today, most departements offer such centres but with great variation in coverage. Each year as many as 100,000 people may spend time as residents of these centres, 40% of them being families with children. But shelter is coupled with counselling services, health care and vocational training, with sheltered workshops being in some cases attached to the hostels. This development, increasingly evident during the 1980s, must be seen in the light of the efforts in France to make the provision of social assistance a means of re-insertion into normal living milieux (see Section 3.4 below). Nevertheless, the poor state of the labour market means that in general, what was intended to be a temporary support fails to secure such reinsertion for the persons concerned.

Cases 4, 5, 6 and 7, presented below in three boxes, summarise the services available in some of these and related areas.

3.4. SOCIAL SERVICES FOR OCCUPATIONAL REINSERTION

As seen in Section 2.4, there are in many countries important links between the social services and employment policy. These links are long-standing: even in pre-industrial times the Poor Law, as well as providing charitable relief to the poor, also exerted pressure on the able-bodied to support themselves through labour.

Section 4.5 of our 1992 General Report dealt with employment policies. Here we refer only to the specific role of the social services in supporting these measures.

Minimum income policies in several member states envisage a "reinsertion contract", under which the able-bodied recipient of cash benefits enters into an agreement for a phased re-entry into normal occupational and social life, but with support from the social services. Thus the French Revenue Minimum d'Insertion, as well as providing financial assistance and affiliating beneficiaries to health insurance cover, involves social and occupational "insertion contracts", by which recipients are given support to re-establish themselves at work and in the local community. So also, the Luxembourg guaranteed minimum income (RMG) was put forward as a "global" strategy to combat poverty, providing not only financial support but also opportunities for entry into training and employment. But this involves stringent conditions on eligibility in terms of residence qualifications: a further important factor in social exclusion, given the large proportion of the population who are foreigners.

In many countries of the Community, there are counselling and advisory services available to the unemployed, especially the long-term unemployed: not just in relation to their search for employment, but more generally in regard to their efforts to cope with labour force exclusion and to overcome specific handicaps, for example illiteracy.

CASE 4: HOMELESS AND UNEMPLOYED DRUG ADDICT AGED 17

COUNTRY	MINIMUM SERVICES	
BELGIUM	Aged under 18, and homeless, this young person is not entitled to social assistance/subsistence income: but a local public centre for social welfare (CAPS/OCMW) has discretion to provide financial assistance. Can turn for help to NGO for homeless. Drug use illegal: special court for juvenile delinquency can oblige young person to attend a withdrawal course in specialised centre; or be placed compulsorily in special "youth home". Homelessness means the youngster can be arrested for vagrancy.	
DENMARK	Local authority has responsibility for young people at risk: includes this 17 year old. Youth Centres offer resident and day treatment services for narcotics and alcohol. (provision is a statutory responsibility laid on counties). 1350 clients in January 1992.	
GREECE	Not even temporary shelter is available Some detoxification programmes available in largest cities	
SPAIN	National Plan on Drugs (1985) has promoted municipal action and work of voluntary organisations: programmes for young people. Emphasises social integration, partly by vocational training. Lack of information to evaluate effectiveness of programmes. Detoxificaton units: but waiting time for entry almost on month.	
FRANCE	Access to various hostels (funded under auspices of Aide Sociale of departement, housing funds, etc) Access to detoxification centres and psychiatric hospitals.	

COUNTRY	MINIMUM SERVICES	
IRELAND	1991 Child Care Act, when in will raise from 16 to 18 the age of young people who can be made responsibility the public authorities. But 17 years olds currently beyond age of State concern. Community-based addiction counsellors (employed by a number of health boards) Needle exchange programmes in Dublin. Health board drug treatment services include day hospitals, community programmes, drug and alcohol units.	Drug treatment programmes force, for young people require parental consent: homeless young people out of touch with of their families are thus excluded. Also rely on self-presentation by young person. Some limited emergency accommodation is offered.
ITALY	Eligible to be placed in a group living/therapeutic community (mainly voluntary organisations), but overcrowded and long waiting lists: family approval/cooperation necessary: if absent, juvenile court can intervene/take charge. Also entitles to income support and subsequent help in job search (but no priority in public housing). The public authorities have in recent times adopted a harsher stance towards drug addicts: they can be obliged to accept compulsory treatment in a therapeutic community as an alternative to imprisonment (Fasalo, 1992).	
LUXEMBOURG	Clinics for detoxification Residential care in one psychiatric clinic (but other refuses because client is a minor) Therapeutic centre offers combined programme of therapy, housing and work Some units of housing available from asssociations dealing with socially excluded groups Association Jugend a Drogenhellef advises on treatment	

COUNTRY	MINIMUM SERVICES	
NETHERLANDS	Any use of social services is voluntary No social assistance entitlements: but some municipal social services may nevetheless use their discretion to pay a benefit Reception centres for homeless in larger cities: but some are conditional on receiving treatment to end addiction Counselling Centres for Alcohol and Drug Addiction: advice, rehabilitation, medical care Employment: Rotterdam municipal social servicies offer a programme of rehabilitation which includes vocational training.	
UNITED KINGDOM	National Health Service Mental Health legislation may apply and therefor residential care Homelessness legislation: does not cover this age/need group Social services: none mandatory Voluntary sector	Wide variation likely between local authorities in the social services provided. Might be offered housing, if homeless families with children have all been accommodated Very important in this field

CASE 5: SERVICES CONCERNED WITH DEBT SITUATIONS AND PROCESSES (RENT, ENERGY, CONSUMPTION)

COUNTRY	MINIMUM SERVICES
BELGIUM	Assistance by centres for public welfare (CPAS/OCMW) and some NGOs with household budgetting for fuel debts.
GERMANY	Municipal offices for advice on debt and budgetting; similar services by private welfare organisations.
GREECE	Emergency fianancial support available; no additional services
FRANCE	Renegotiation of debt payments, mediated by debt commissions (1990ff). Covers all of France, but great variations in usage (F*64-5). But in general not available to poorest families, who have to rely on social assistance agencies.
IRELAND	Emergency financial support available through Loan Guarantee Fund administered by Society of St Vincent de Paul, but coupled with budgeting adevice and renegotiation of debt repayments: financial advice also available forum Financial Information and Advice Centres (22 centres around country).
ITALY	No debt counselling services; only lump sum payments to help with debts in extreme cases
LUXEMBOURG	Association established recently - on German model - to mediate between debtors and their banks
NETHERLANDS	Municipal social services and various private organisations (notably PLANPraktijk/Consument en Huishouding) provide household budgetting advice and negotiate with creditors for restructuring of debt. National Assistance Act allows municipal social services to grant loans/donations to assist in this. Municipal Credit Banks and Municipal Guarantee Funds enable municipalities to take over debts. As part of a programme of repayment agreed with debtor.
UNITED KINGDOM	Citizens Advice Bureaux throughout country (partly subsidised by central and local government): an increasing proportion of their time is spent on debt counselling. In some local authorities, welfare rights units will advise on financial problems.

CASE 6: SERVICES CONCERNING EMERGENCY SITUATIONS (RECEPTION CENTRES OPEN 24 HOURS A DAY)

COUNTRY	MINIMUM SERVICES
BELGIUM	NGOs offer telephone emergency services: advice on social, psycho-social and material problems NGOs : Reception centres for the homeless (including some for women) Police services
DENMARK	Women's shelters (DA: 40)
GERMANY	Shelters for women and children at risk; ambulant services less well developed
GREECE	Emergency health services as hospital only
SPAIN	Recently-created shelters for women
FRANCE	Many types of emergency services in the cities: including emergency shelters catering for particular client groups. Rarely open 24 hours a day. Variously funded by central government, communes, poverty funds, private donations. Social workers and volunteers provide support.
IRELAND	Emergency hostels - some public, others voluntary sector - are available, especially in Dublin, some restricted to particular categories: adolescents, women, etc. Many of the voluntary shelters receive health board funding. Advice and counselling services to those suddenly rendered homeless are offered by such agencies as Focuspoint, again in Dublin Childline is an 24 hour emergency telephone service for child at risk
ITALY	Apart from the emergency rooms of hospitals, there are virtually no public emergency centres open 24 hours. A few volunteer centres for women and children. Reception shelters are available to temporary homeless, managed by local authorities or non-profit, mostly Catholic, voluntary organisations (often financed by local authorities). Emergency phone numbers - for women, for children, etc.. (IT*10)
NETHERLANDS	Crisis centres and reception centres, depending on nature of emergency. Some are specifically for women and children
UNITED KINGDOM	Emergency accommodation for homeless single people: depends on voluntary organisations in different areas.

CASE 7: LEGAL AID (APPEALS AS A RESULT OF ADMINISTRATIVE DECISIONS, CIVIL LITIGATION...)

COUNTRY	MINIMUM SERVICES	
BELGIUM	Public initiatives for legal aid	Legal aid lawyer CPAS/OCMW legal advice (in house or local lawyer): some barriers + difficult to advise on CPAS appeals
	Antwerp municipality	Local ombudsman: may be imitated more widely
	NGOs	Many free legal advice centres (1960s) have closed down
	Labour unions and pillarised health insurance funds provide legal advice to members	
GERMANY	Free legal aid for low income groups	
GREECE	Court costs exempted for low income groups	
FRANCE	Free legal defence in cases of litigation for those lacking resources, subject to decision of office of legal aid.	
IRELAND	Social welfare benefit appeals: can be helped with costs of employing a private solicitor, but only if appeal is successful (IRL*61). Appeals can ultimately be taken to Ombudsman (since 1983) - free of charge - and High Court State-funded legal aid scheme (1980ff): civil cases only, and legal representation rather than advice (IR*62). But legal advice and legal aid subject to complex means test. Lengthy waiting lists; under-funded, under-staffed, and law centres evenly distributed geographically (IR*63). Voluntary organisations: some additional legal aid and advice services e.g. Community Law Centre in Coolock, supported in part by Combat Poverty Agency.	
ITALY	Public sector	Maybe in some areas: citizens' offices; local ombudsman; legal advice within family clinic; free legal aid.
	Voluntary sector:	legal advice centres, women's defence centres

COUNTRY	MINIMUM SERVICES	
NETHERLANDS	Citizens Advice Bureaux (local government funding): advice / information, especially social security and tax problems Legal Aid Centres (Ministry of Justice funding): advice / information, especially on labour law, social security, tenancy, residence permits for aliens; plus free/nearly free services of lawyer. Law Shops (staffed mainly by lay people): mainly act on behalf of groups with common interests: housing law (neighbouhoods of urban decay), social security and taxation All the above are publicly financed and offer legal aid	
UNITED KINGDOM	National legal aid scheme (means-tested). Fairly complicated: applicants may seek help of Citizens Advice Bureaux in order to establis rights.	

In Luxembourg, services for social and occcupational reintegration are offered to the unemployed, to new entrants to the labour market and to recipients of the RMG, by a variety of public agencies and NGOs including social support by "social action services" (including the socio-medical centres mentioned earlier); employment training by centres for vocational training. However, gaps between the social and training elements are very evident.

The social services are, however, also involved in controls on the benefits and support which unemployed people receive. Thus, for example, in Belgium applicants for subsistence income must submit to being visited by a social worker to check on their need and entitlement. Work tests, reduced in the 1980s, are now again under debate, in the context of the reinsertion programmes mentioned above. And in Belgium at least, in the administration of supplementary benefit (local and discretionary), social workers make the traditional distinctions between the "deserving" and "undeserving poor" (Luyten, 1991).

3.5. SOCIAL SERVICES FOR AREAS OF HIGH SOCIO-ECONOMIC STRESS

Certain types of area are particularly vulnerable to high rates of social stress. These commonly include inner-city areas with high rates of population turnover; social housing estates with high proportions of families; and depopulated rural areas, with high proportions of elderly people.

In some countries, efforts have been made to identify such areas by means of quantitative indicators, using data which are routinely collected for administrative purposes, in

order to assess the extent to which they should be given priority in the allocation of social service resources. There is a substantial tradition of such analysis in the UK, for example. But this is not to say that indicators of this sort are good predictors of the effort which different local authorities will make in their social services: many other factors intrude, including the political complexion of the local authority.

Nevertheless, it is often in these actual areas of high need that inadequate coverage of social services is to be found most particularly in remote rural areas. Thus in Ireland, for example, it is Greater Dublin that offers the best services for elderly people, along with the area around the urban centres of Cork and Kilkenny. It is rural areas that are least well endowed in such services and in the local authority and sheltered housing which elderly people commonly need. In Greece, similarly, although rural areas have high proportions of elderly inhabitants, services for elderly are concentrated mainly in urban areas. And of course, unless transport links are very good, the concentration of services in the larger population centres means that distance will limit their accessibility to those living outside, another form of exclusion. In Ireland, free travel passes are often available to elderly people, for example, but if there is no public transport, then these passes are useless.

CASE 8: BENEFICIARIES OF MINIMUM INCOME SCHEMES (SERVICE AIMING AT THEIR ECONOMIC AND SOCIAL (RE)-INTEGRATION)

COUNTRY	MINIMUM SERVICES
BELGIUM	Employment and training measures
DENMARK	Counselling and advice (employment, budgetting, housing, health, marital), with aim to restore independence. Recent strengthening of role municipality in channelling able-bodied beneficiaries into jobs
FRANCE	Orientation service, to enable person to negotiate the various element so the RMI scheme Health care insurance where otherwise not covered Housing where necessary (but with consequent reductions in assistance benefit) Programme of insertion: training, subsidised employment, etc.
ITALY	No special services
LUXEMBOURG	Orientation service, to enable person to negotiate the various element so the RMG scheme Housing, health care: offered through medico-social centres Retraining programmes
NETHERLANDS	Municipal social services promote vocational training, including in some cases measures focussed on long-term unemployed. Since 1991, increased scope for reimbursing clients the costs of training. But coercive element also: municipal social services can place a ceiling on benefit entitlement, if client does not take up the activities which have been agreed.

Among the social services which are to be found in such areas of high stress, strategies of community development often play an important role. In Portugal, community development

efforts in Setubal, an important region of industrial decline, have been important. Recently, in a marked break with Belgian tradition, but under the stimulus of the newly-created poverty funds in Flanders in particular, a number of local Centres for Public Welfare, where municipal social services are based, have begun to deal with the structural processes which place stress on family and community networks, working in partnership with local NGOs. Nevertheless, even in Flanders, only a small minority of these centres are actively involved in community development work, preferring to leave this to NGOs. Among these programmes of community development which involves the centres are two of the projects sponsored by the EC in the framework of Poverty 3, in Antwerp (Flanders) and Charleroi (Wallonia).

Community development strategies are being developed by the social services in most other countries of the Community. In some cases - Portugal and Ireland for example - these are in association with the action projects of such Community programmes as Poverty 3. But these efforts can of course be predicated on a variety of different social perspectives. In some cases, especially in the areas of high social stress with which this section is concerned, a diagnosis of the dilapidated state of social networks leads social service providers to rebuild those networks, as the necessary infrastructure of social support. In other cases, if not always in these areas of high stress, it is the abundance of associations and networks that is most striking as community development involves the effort to build new partnerships among them in coherent programmes of social action. Thus, for example, in Ireland, reference has often been in policy debates to the central role of voluntary organisations in mobilising the energies of citizens in order to develop their communities. In Spain, equally, the current attention to the role of the NGOs is partly in terms of their contribution to community development.

3.6. CONCLUSION

In this chapter in particular, the analysis has been gravely vitiated by the lack of suitable data. This underlines the need for data improvements, both in identifying social exclusion and in measuring the effectiveness of policies. At the beginning of this chapter, some of these data requirements were already outlined. But two further sets of comments may now be added.

First, it was argued in Section 3.5 that social stress - and the need for intervention by the social services - was liable to be high in particular sorts of geographical area (while not suggesting that any area entirely lacks such needs). This suggests the need for spatial indicators of social stress, ideally making use of data that are already being collected for normal administrative purposes. There are precedents for this in some countries of the Community.

Second, it was argued early in Section 3.3 that improved data on coverage of services were needed, including the resources deployed. Table 3 illustrated what comparative tables might then be developed for the different social services and the different population groups with which they are concerned. However, it may also be possible to suggest some clearer indicators of social exclusion in relation to which the social services can be judged. Drawing together suggestions within the national reports commissioned for this study, these might, first, include specific forms of social exclusion to which the social services are commonly addressed. As noted at the beginning of Section 3.3, these include social isolation (which may, for

example, be caused by disability) and confinement (as experienced by those in residential institutions, but also by those who care informally for people with special needs within their own home). These also have provided repeated points of reference through this chapter, even if it has not been possible to use them as well-defined, even quantified, indicators of social service effectiveness.

Other, rather different, indicators of effectiveness which some of our national reports have employed refer to the success of new initiatives in establishing networks of social services and in mobilising larger partnerships and coalitions of social services. Therefore in Spain, the Concerted Plan of Social Services (1988) stimulated the development of local social service centres in most municipalities, offering general advice and family support: the effectiveness of the centres themselves cannot yet be evaluated, but the extensiveness of the development at least provides a criterion for judging the effectiveness of the Plan.

CHAPTER 4: THE SOCIAL SERVICES AND SOCIAL EXCLUSION

4.1. INTRODUCTION

Chapter 2 examined the organisation of the social services, the role of public and private agencies, the role of central, regional and local government, the relationship between the social services and other branches of social policy. Chapter 3 was concerned with specific social services, the rights and entitlements which they offer to citizens and their effectiveness in delivering these entitlements.

The present chapter, building on the preceding discussion, examines some of the barriers to access which users encounter and the processes of generalised and persisting disadvantage that they suffer as a result, along with their reduced levels of social and occupational participation. More particularly, it is concerned with:

* professional discretion and the exercise of social rights;

* exclusion through the price mechanism and rationing;

* the under-use of services by those who people who have the weakest social networks, as compared with those in less vulnerable positions;

* variation in level of provision resulting from the local organisation of services, where this jeopardises social equity and leads to the neglect of areas of high stress;

* fragmentation and inaccessibility of services;

* the exclusion created by institutionalisation and the new forms of exclusion which de-institutionalisation may allow to develop;

* the social exclusion of informal carers;

* criteria of ethnicity and nationality which can mean that "foreigners", although having high levels of social need, are largely ignored;

* social exclusion and social control.

4.2. DISCRETION AND RIGHTS

Rights to social services are in general ill-defined. This is in part because with any form of service, as distinct from a cash benefit, entitlements are mediated by professional workers, whose judgement of need involves considerable discretion and cannot be converted into a clear formula. But it is also because in many countries social services remain partly

outside the public realm, with private organisations left responsible for them. And, finally, it is also because in some countries, social services remain closely linked to the charitable tradition of social assistance, rather than to notions of citizenship rights.

In some countries, for example Luxembourg, debates are under way concerning possible new legal frameworks for the social services, which could be used to define minimum standards and which would enable service users to have recourse to legal action against the service providers. In the UK, the present government has given a central place to citizens' charters, defining clear standards of service which service users can expect and be compensated for when they are not met.

Yet of course, such standards, and citizens' power to enforce them, cannot themselves ensure that the human and financial resources which are necessary are available. In Italy, a new national regulation has recently been issued, making hospital doctors and nurses directly responsible if an emergency patient is not given attention because of overcrowding, even while other services, including prisons, continue to off-load their difficult cases into the hospitals. In a number of countries, for example Luxembourg and France, there are fears as to the quality of social service personnel, particularly in face of the growing scale of the needs which they are required to meet; and fears that too severe standards could force some services to close before others are ready to take their place. This low quality of personnel is in part linked to the low status of social services, where these still bear the stigma of poor relief.

4.3. EXCLUSION THROUGH THE PRICE MECHANISM AND WAITING LISTS

In some cases, services may be available to particular categories of need, but charges are then levied depending on the financial resources of the recipient. These charges may not be uniform nationally. In other cases, services are restricted altogether to those below a particular income level, they are in other words services for the poor, but to them they are free of charge. In the latter case, the services are often stigmatised, while those on modest incomes, just a little above the specified threshold, find themselves in a particularly difficult situation.

In France for example, ambulant care for the elderly is offered on the basis of professional definitions of need (by no means standardised), even if charges are then levied in accordance with the person's financial resources. Nursing care, the medical elements at least, is free of charge. In the case of residential care, charges are reduced in the case of the lower income groups, with the social assistance system providing the subsidy. More generally, there appear to be moves towards a system of charges for social services, differentiated according to the income of the client, and/or with the incomes of the poor being supported through the RMI. (This provides another example of the market liberalism of recent French social policy, parallelling in certain respects that of the UK, albeit under an ideologically very different central government: cf. section 2.2).

Waiting lists provide an alternative method of rationing scarce services. In several countries, the length of waiting lists is being used as a performance indicator, in the UK and in Portugal, for example. But waiting lists can also of course be taken as indicators of unmet

demand, as happens in France. In Luxembourg, recent years have seen a dramatic lengthening in the queues of people awaiting entry to nursing homes: even those in greatest need of admission currently have a two-year wait. It is partly in response to this crisis that care allowances have been introduced, to support care in the home.

What such waiting lists fail to show is the number of users who withdraw, discouraged, or who fail to register their demands for services, because of the administrative barriers which they experience: the problem of non-take-up. In many countries, however, there is a remarkable lack of information as to the non-take-up of social services. In Belgium for example, recent years have seen only a few studies, including one dealing with access by migrants (see below), and another on the non-take-up of cash benefits.

4.4. DIFFERENTIAL USE OF SOCIAL SERVICES

Social services may be "universal", open to all citizens, rather than to the poor or those who have established specific insurance entitlements. However, as with all such services, demand is liable to outstrip supply. In these circumstances who manages to secure the services they demand and who tends to lose out?

In some cases, users are in practice drawn disproportionately from among the lower income groups. Thus, for example, in the UK the introduction into the benefits system of the "Social Fund" - providing loans, rather than grants, to those on low incomes and with emergency financial needs - has given rise to fears that social workers will be asked by social fund officials for advice on clients' ability to repay.

However, where this social control function is less marked, there is some evidence that those whose resources and whose social support networks are most precarious receive less attention than their more fortunate neighbours. In Denmark, elderly people with a strong social network often receive more help than elderly people with a weak social network. This is probably due to the fact that the former are more aware of their rights, have more resources, and get support from their network to receive the full help, while elderly people with weak social contacts have more difficulties in receiving the necessary help. Similarly, studies in Greece suggest that large numbers of people living the less privileged areas of the capital, Athens, are unaware of the services that are available: the less poor are less ignorant. The result is that individuals who are better informed, better initiated into the working of the State bureaucracy, or better connected, may claim multiple benefits, while others who are entitled claim no benefit at all. In Ireland, those who are on low incomes may not be able to afford transport to some forms of care, for their own needs or to visit relatives receiving institutional care: again, the services are unintentionally biassed against the poor.

In Denmark, again, as seen in Chapter 3, day care places for children tend now to be given more to employed than to unemployed parents, as a result of recent changes in the administrative rules on the unemployed and allocation of day care places. The segregation and exclusion of the unemployed and their families are thereby only reinforced. More generally, services related to education and day care tend to be used disproportionately by the higher socio-economic groups, primary health care and home help by the lower. In Italy, similarly,

privileged (cf. Tosi, 1989). This is certainly true of leisure and cultural services; the lower strata use more the social assistance services such as community meeting centres, home care and summer residences for elderly people and children.

In France, the limited amount of public childcare tends to be used disproportionately by the better-off, especially those forms that are most costly for the local municipality, producing a regressive redistribution of resources towards these households.

In Spain, too, there are already fears that the new social service centres, established under the Concerted Plan of Social Services of 1988, although directed at the population in general, may prove to be insufficiently accessible for specific underprivileged groups. In addition, the drive towards the "professionalisation" of the social services, and towards the improvement of the status and social esteem of social service professionals - may tend to reduce their concern with morally dubious population groups.

In the UK, although the social services are not limited to those on low incomes and are intended to be universal, small-scale studies of local areas suggest that most users of the social services are claimants - i.e. they depend wholly or partly on benefit payments. Now there are fears that the "mixed economy of welfare" will accentuate this, as "choice" enables the better off to pay for private services.

In all of these cases, the inequalities arise in part because it is often difficult to formulate specific entitlements or rights to social care. Where rights are unclear, discretion and negotiation are crucial in determining what services are received. In these circumstances, the resources and support which a person enjoys are of particular significance. This is quite different from the case of social insurance benefits, which to some extent have the status of legal entitlements (especially in countries such as Germany, where the social insurance funds are based on contributions from employers and employees but, in principle, not at all from government and are administered by bodies which, although governed by public law, are non-governmental: Landwehr, 1992, p. 4).

4.5. LOCAL VARIATION AND SOCIAL EXCLUSION

Local variation in social service provision appears to be common to all the countries of the Community. This is as true for Denmark, with its universalist services, as for Greece, with services of any kind very under-developed, and those that exist very unevenly distributed, so that in some areas many bodies are offering the same services to a small proportion of the population. For in all these different regimes, local autonomy in service provision is markedly greater than in most other fields of social policy; and the definition of national standards, against which local effort and performance can be judged, is relatively weak.

This variation is being reinforced by some of the recent policy initiatives recorded in our reports. In the Netherlands, the Social Renewal Policy of the 1990s has meant that municipalities now receive from central government, not a series of different budgets awarded under different national programmes, but rather a lump sum, on the basis of plans submitted to, and approved by, central government. But this in turn allows municipalities greater autonomy

and approved by, central government. But this in turn allows municipalities greater autonomy in the implementation of their social programmes, and greater diversity is likely among them (Pijl, 1992, p. 3).

Of course, much of this local variation must be understood in relation to variation in the extent and pattern of need for services. It is the relationship between the demand for, and the supply of services, that is important. (Of course, when it comes to cross-national comparisons of the extent of unmet need, it must be recognised that country-specific institutional factors can stifle or stimulate demand and supply and can render such comparisons difficult.) But variations in supply, relative to demand, are relevant to our analysis of social exclusion in two senses.

First, the lack of nation-wide standards may mean that some local areas with high levels of social stress are especially neglected, leaving high-risk groups within them facing major barriers to their re-inclusion in mainstream social institutions. These areas - most obviously those in urban areas - have been highlighted by social researchers from a variety of different backgrounds as liable to exhibit high rates of social pathology (Lewis, 1962; Seebohm, 1969; Carbonard, 1979; Wilson, 1985). Section 3.5 above referred to these high-risk areas.

Second, local variations mean that people living in certain areas may not have access to the levels of certain services available in most other areas of a country, or may face higher charges. This is a problem of social equity. But it may also be that the services generally available in one local area fall below the basic minimum standard which is accepted across the rest of the country concerned. This is a problem of social rights.

Thus in Denmark, the Social Assistance Act specifies which services should be offered to citizens by the municipalities, but leaves the latter to decide at what level to supply these services and in what way. In consequence, decentralisation of services has resulted in, sometimes unacceptable, differences in the municipal level of service. This problem has provoked debate concerning minimum standards and minimum rights for the citizen. The distribution of private services varies even more and in some cases they are non-existent.

In France, similarly, there is wide variation in such basic social services as home helps, public crêches and emergency shelters, some of these services being wholly lacking in some communes. The density of provision of residential care also varies greatly, the best endowed departements are twice as well provided as the least well, in terms of residential beds for members of the elderly population. Moreover, in respect of emergency shelters for the homeless, perverse disincentives confront municipalities which may wish to raise their standards of provision in order to avoid the risk of attracting clients from neighbouring municipalities which are less well endowed.

In Italy, the allocation of responsibility for social services to local government means that, in the absence of common defined standards and specified minimum levels of services, there is great local differentiation which has little to do with local differentiation of needs. Citizens have no formal, nationally defined rights to specific provisions, within the range of those left to local responsibility. There are, similarly, considerable variations in expenditure patterns between different municipalities. Data for 1986 revealed that almost everywhere, services for the elderly absorbed almost 50% of social assistance expenditure, but expenditure on children, for example, varies between 11% and 78% of such budgets. And the cost per

with whom it deals. These cost variations reflect in part different packages of services being offered bearing in mind that institutionalisation being in general more expensive than ambulant services, but also, possibly, variations in costing conventions (for example, whether the wages of local authority workers should be included). This underlines the lack of standardised data conventions which would permit monitoring.

These inter-area variations are also evident within particular services. In Italy, again, services intended to make institutionalisation of elderly people unnecessary are very unevenly distributed across the country. So also are services for people with physical or mental handicaps. Thus the South is better-endowed in terms of residential institutions and the number of workers in each institution, but worse in terms of psychiatric day and emergency services, sheltered housing and small communities for handicapped people, as well as in terms of the numbers of psychiatric workers per head of population. Similarly, it is in the South that children with handicaps are more likely to be segregated within educational institutions. And in terms of the staffing available, in the South there is a prevalence of medical and paramedical professionals but a scarcity of qualified social workers. Activities intended to promote social integration are therefore correspondingly weaker. Finally, it is principally in the centre and north that new day hospitals and protected small communities are being created for the young and adult mentally ill, after the closing down of psychiatric hospitals.

Finally, local autonomy leads to great variation in charging policies, even within a given country. It is common for clients to pay something for such ambulant services as home help or meals-on-wheels. But in Ireland, for example, there have been calls for greater uniformity in charging procedures, as well as an effective system of remission for lower income groups.

4.6. FRAGMENTATION AND INACCESSIBILITY OF SERVICES

The "mixed economy of welfare" expresses many different ideological currents, as seen in Chapter 2, subsidiarity in Germany, pillarisation in the Netherlands, the pursuit of a liberal market economy in the UK. Common to all, however, is the risk that a multiplicity of providers will produce duplication, fragmentation and confusion as regards access. Lack of information is one of the main barriers in access to the social services. It costs much time and initiative to find out which institution offers what, where and under which conditions. As a consequence, potential clients may approach the services only when problems have grown to a stage where help may be more difficult than before. And their needs risk being labelled differently, depending on the specific service and channel through which they are helped, even where these differentiated channels have no rationale in terms of the needs themselves.

Some efforts are under way to overcome these problems and the barriers to access which they often create. In Luxembourg, a variety of "conventions" and legal frameworks, involving the central government and non-governmental social service organisations, provide some measure of coherence in planning and implementation. In the Netherlands (see Section 2.2 above), there have been efforts to reform the fragmentation of services produced by a history of pillarisation. Local government as well as provincial government have attempted to restructure the social welfare organisations in order to improve efficiency, for instance by stimulating cooperation and merging. However, the results of the restructuring have been less

stimulating cooperation and merging. However, the results of the restructuring have been less than expected, with the costs exceeding the savings during the initial years. Furthermore, ideological links with the former pillars remain, providing the organisations with influential advocates against merging. In France similarly, despite repeated calls for improved coordination of services for the elderly, little seems to have been achieved (save for the practical cooperation between different agencies in a given locality, which is based on mutual goodwill rather than any coherent framework). The vested interests of the existing agencies have in general proved too formidable and resistant to reform.

Even within the public sector, problems in demarcating the boundaries between services can result in duplication and barriers to access. These "boundary disputes" are most common between health and social services, for example in relation to physical disability and mental handicap In Greece, where education, health, and social security all have a role in dealing with these groups, there have been attempts centrally to overcome unclear responsibilites by creating a Directorate within an amalgamated Ministry of Health, Social Welfare and Social Security. In Ireland and Portugal the administrative integration of health and social services may remove some of these coordination problems, but this can be at the expense of some aspects of social service most removed from medical concerns, including the promotion of community development, volunteering and the "caring capacity" of the community. However, with the priority which is now being given throughout the Community to policies of "community care", effective cooperation between the social services and these other branches of social policy, including the police, is becoming imperative, to enable people to move out of institutions and back into the community.

4.7. INSTITUTIONALISATION AND SOCIAL EXCLUSION

Many of the developments in the social services during recent decades have been intended to promote de-institutionalisation, ie the shift from residental institutions to ambulant care. This has admittedly, not had the same importance as a policy goal in all of the Community countries, for example, Denmark (Jamieson, 1991, p. 118-120). Even there however, the 1980s saw significant falls in the numbers of persons in nursing homes and in residential institutions for the disabled and for children.

At one level, institutionalisation can be regarded as itself being a form of social exclusion. And, notwithstanding efforts to move away from institutional provision, in some cases the numbers of people in institutions are increasing. In Ireland, for example, between 1980 and 1986 the number of people in long-stay geriatric establishments, both public and private, increased from 12740 to 14220. But in many cases, institutionalisation is for social reasons rather than medical, for example, residential provision would not be needed if other services were available, or if social policies enabled families to cope more adequately with their dependent members. In Ireland, official estimates are that nearly one third of those in long-stay geriatric units are there for these social reasons, and that four fifths of those in psychiatric hospital are suitable for care in community hospitals and residential centres.

This does not mean that de-institutionalisation necessarily avoids social exclusion. In Denmark, again, it has been criticised because, notwithstanding the impressive array of public

institutions, the less their initial capacity to manage by themselves and the greater their likely need for social service support, if they are to avoid this isolation. Meanwhile, the remaining institutions now hold those who are most disabled and who require higher levels of staffing and care. In Denmark, recent years have accordingly seen a growing number of specialised units with high staff:resident ratios. And in Germany, the call is for nursing rather than residential homes.

Residential homes for young people normally offer an alternative to placement with a foster family or adoption. In the UK at least, the numbers of youngsters in such homes remains substantial, even if less so than formerly. Recruitment is disproportionately from low income and incomplete families, and, as seen earlier, it is older children and adolescents. Instead, many of them tend only to "contain" difficult youngsters. And even in terms of retaining some remnants of a youngster's family network, by keeping siblings together, many homes fail. For this age group in particular, penal policy and social services provision are closely inter-related. Reductions in the use of custodial sentencing may, for example, affect the population of youngsters requiring residential care by the social services.

4.8. THE SOCIAL EXCLUSION OF INFORMAL CARERS

The family was traditionally taken to be the principal provider of care and support. How far this remains the case varies, as seen in preceding chapters. So also, therefore, does the status of the informal carer, typically a woman, who may variously be seen as discharging a task on behalf of the community as a whole or an entirely private responsibility. This will, in turn, influence whether such a carer receives any financial recompense or is offered external support in the form of respite care, for example, in the case of infirm elderly and disabled dependents.

In Germany, there has been extreme reluctance to pay informal carers any compensation for their efforts. The principle of subsidiarity stresses the first importance of family responsibility. Nevertheless, it is evident that care at home is often preferable to care through formal services, not least on grounds of cost. Some limited payments are therefore now being made by the insurance organisations, in part to allow respite care (Jamieson, 1991, p. 115). Allowances are also being developed in France. In the Netherlands, there has recently been some recognition of those who care informally for elderly people. This has so far been limited to pilot projects. However, the current efforts to reduce the numbers of people living in institutions are likely to raise public concern about the burden faced by carers and this may well be reflected in continuing growth in the public resources made available to support them.

In Denmark, however, there is little stress on the responsibility of relatives to offer care (Jamieson, 1991, p. 120). On the contrary, one of the major factors behind the expansion of the social services during recent decades has been the rising female participation rate on the labour market, with the rate for women - both single and married - in the 30-40 age range now close to that of men. A large part of the care functions for children, the elderly and the disabled which were formerly attended to by women have therefore been taken over by the public sector. Even so, in the case of child care there remains much unmet demand for places. If a mother cannot obtain child care, she may be at risk of having to give up her job; and without

sector. Even so, in the case of child care there remains much unmet demand for places. If a mother cannot obtain child care, she may be at risk of having to give up her job; and without child care she is not available for work and hence cannot claim unemployment benefit. The same dilemma faces women carers generally. The burden resulting from the lack of public childcare services invariably falls on the shoulders of women. Women who are unable to secure a place for their children are often forced to stop their work, or are unable to take up work.

There is plenty of evidence to show that informal carers are at substantial risk of social exclusion. They tend to withdraw from the labour market, or not to enter it in the first place. In a period of women's increased and increasing participation in the workforce, those who are obliged to withdraw are withdrawing from normal patterms of social integration. Carers also tend to have lower levels of income and thus to be excluded from some of the dominant consumption patterns of the mainstream of society. They tend to be tied to narrow social mileux, centering in the home itself. Only in recent years have they become in some countries somewhat less politically marginal, by dint of the emergence of political pressure groups working on their behalf.

Against this, however, some of the moves towards de-institutionalisation discussed earlier may have the effect of worsening the position of carers. Greater reliance on the informal sector is motivated in part by concerns about funding, even if new costs are imposed on carers. For example, in Greece, the promotion of volunteering and family and community as service providers is linked to the attempt of the state to constrain public expenditure.

4.9. THE SOCIAL EXCLUSION OF "FOREIGNERS"

Section 3.3.4 was concerned with the social services which deal specifically with immigrants and refugees. However, it is here however worth examining further some of the processes of generalised and persisting disadvantage that such people suffer as a result of the inadequacies which have been identified in the social services.

The barriers which they face in access to the social services make for a high risk of social exclusion. Firstly, the geographical variations in social service provision (see Section 4.5 above) can be of particular relevance for immigrants. In Italy, for example, in the large metropolitan areas of the centre and north some effective efforts are being made at cooperation between social services, NGOs, the police, etc, to meet the worst needs of immigrant families; in the South, however, where clandestine immigrants appear to be particularly numerous, the level of such intervention is much lower. Secondly, the forms of emergency accommodation that are available, together with visa restrictions, mean that it is difficult for children to join and to live with their parents, and for a family thus to re-constitute itself inside Italy: Family networks are thus placed under severe stress, but the Italian social services do not give these needs priority. Thirdly, many of those who cannot remain legally in the country do so on a clandestine basis, but as a result they are excluded from the social services and most other forms of social protection.

No less significant for risks of social exclusion, however, are the opportunities which the social services provide for communities, in this case, foreigners and immigrants, to organise themselves as networks of mutual aid. For, as indicated in Section 1.4, the social services are commonly involved in community development, and not just the delivery of services to individual clients. However, here some significant differences in national policy are to be found.

In Belgium, recent years have seen resistance to the subsidising of immigrant groups who want to organise for themselves their own religious and cultural institutions. Within the Belgium system of pillarisation (similar to the Dutch), such institutions are viewed as potential new "pillars". Instead, immigrants are expected to fit into the existing organisational structure of the Belgian pillars. The Dutch government appears less averse to offering such support. Government subsidies to the national bureaux of twenty-nine such associations amounted to approximately 2 million ECU in 1991 (Pijl, 1991). In Germany, similarly, especially in large cities with a high percentage of foreigners, self-help groups and other initiatives receive financial support from public sources, as a means of promoting integration and the preservation of cultural heritage (Landwehr, 1992, p. 44).

A second strategy of inclusion is also evident in Germany. There, foreigners are dealt with by three of the private welfare organisations, Caritas, Diakonisches Werk and Arbeiterwohlfahrt, which have each taken responsibility for workers from specific countries with whom the German government has concluded bilateral agreements (Landwehr, 1992, p. 43). In one sense, this represents the normal efforts by these private welfare organisations to offer social support to needy groups. At the same time, however, this segmentation of the immigrant population can be seen as being in part a form of confessional stabilisation or pillarisation: this is most obvious in the case of Caritas, responsible for workers from the Catholic countries of Italy, Spain and Portugal.

As yet we have little information as to the role played by the self-help organisations of immigrants, including those rooted in the countries of origin. Yet, as Miller has shown, these organisations are major social and political actors, at least in providing immigrant workers with a focus for their collective aspirations (Miller, 1981). Their partial exclusion from the processes by which public policies towards immigrants are formed is itself a policy decision by the host country.

4.10. SOCIAL EXCLUSION AND SOCIAL CONTROL

As argued in Chapter 1, the social services may be involved in social control as well as social care. Subsequent chapters have dealt with various instances of this, for example, ble-bodied social assistance recipients, where the social services may be involved in efforts to impel them back into the labour market; immigrants, where the social services may limit the forms of self-organisation and social integration that are permitted; drug users, young offenders and vagrants, where the different provisions of the welfare and penal laws may be in conflict. These are of course all groups whose moral credibility is regularly placed under threat by opinion-leaders. These chapters have also referred to the dilemmas of intervention in the family, in cases of child protection.

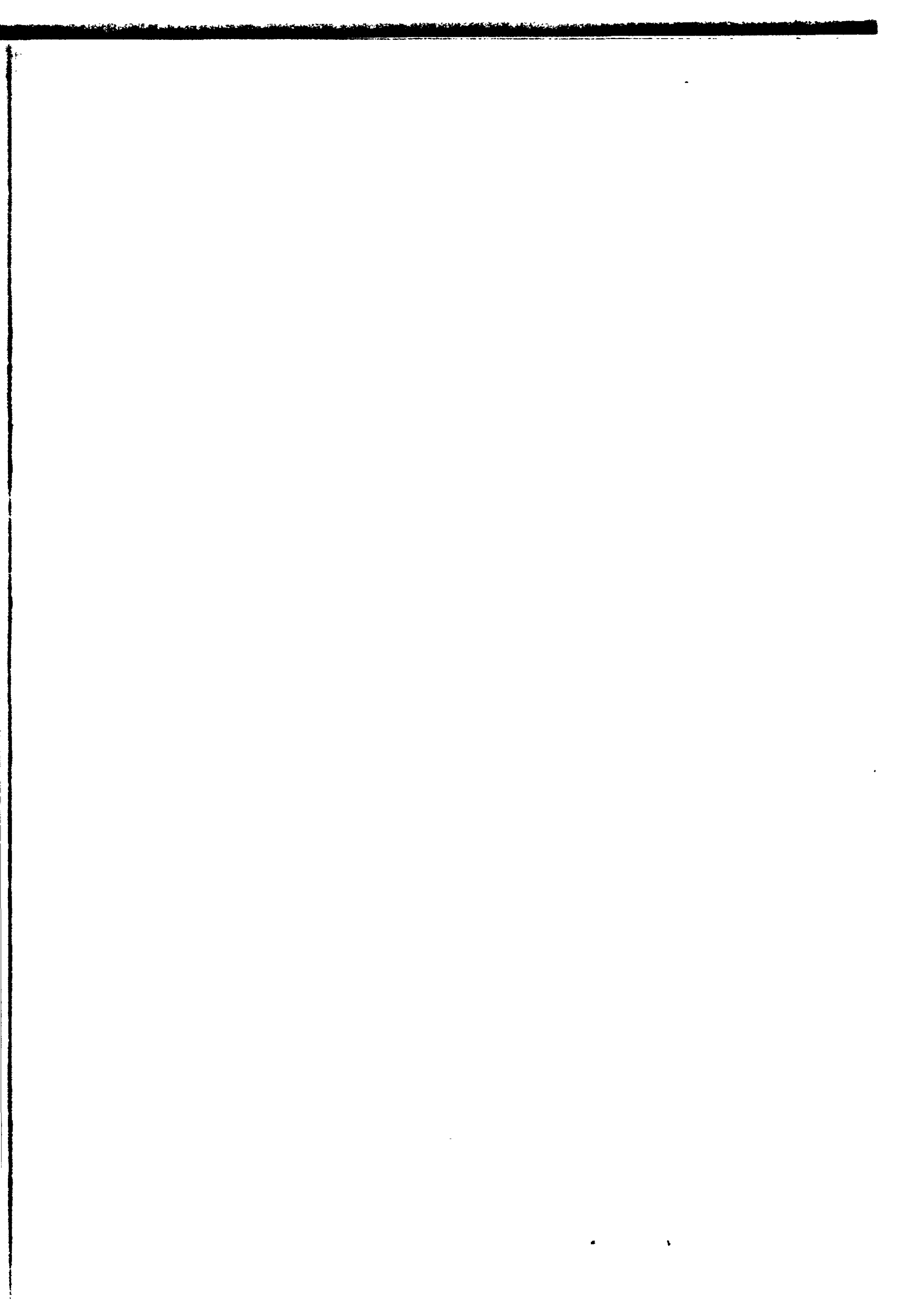
Social service workers may well have a crucial role to play in enabling people to negotiate the complex range of services and benefits open to them. But at what point does this role become one of social control? This question arises particularly sharply in the case of l'accompagnement social - social guidance - in France. There, social workers have had the task of looking after children at risk and, indeed, adults as well. This supervision, currently involving perhaps 300,000 adults and 75,000 children, has often been criticised as involving social control. New risks of exclusion now threaten new categories of the population, who are unable to make full use of existing benefits and services. L'accompagnement social aims at reintroducing these people into housing, a neighbourhood, an economic activity, a therapy, within a "contract" or framework agreed between the client and the social work "guide". This specifies rights and duties on each side and aims thereby to avoid too asymmetric a relationship: but it leaves unresolved the limits of social control by the social services.

Appeals procedures represent a check on the arbitrary use of discretion by social service workers or a control in the hands of the client. These vary in their effectiveness, however, in part because of the difficulty of defining needs and entitlements as far as social services are concerned. In Belgium, appeals against decisions on the services to be provided by the Centre for Public Welfare (CPAS/OCMW) are handled by the provincial court of appeal. However, the annual number of complaints doubled during 1980s; and during that period, the average time for dealing with an appeal lengthened dramatically to 157 days (60 days being the legal maximum).

4.11. CONCLUSION

This chapter has been concerned with the processes of generalised and persisting disadvantage that people suffer as a result of the inadequacies which have been identified in the social services, along with their reduced levels of social and occupational participation. But it has also related these patterns of disadvantage and exclusion to wider variations in power and advantage and to broader policies of inclusion and exclusion of particular groups.

Public and private organisations deliver social services to specific clients. But those clients are also citizens, located within specific networks and involved in specific forms of social, political and occupational participation, on the basis of which they aim to use the social services to consolidate and improve their life chances. Other citizens may variously support or resist those efforts, depending for example on the degree of public esteem for the group in question and the costs which services place on citizens at large.



CHAPTER 5: THE COMMUNITY DIMENSION

As explained in the opening chapter, this study was undertaken in part to meet the policy information needs of the European Commission. In 1992, one of these information needs was to explore problems of access to social services, with a view to possibly preparing an initiative in this area.

This chapter suggests four elements which, while respecting the principle of subsidiarity, might be relevant to such an initiative.

5.1. IMPROVEMENTS IN DATA

In the field of social services, more perhaps than in any other, the work of the Observatory is limited by the lack of up-to-date and comparable data on patterns of social exclusion and on the effectiveness of different social services. These deficits reflect the absence of any common conceptualisation of the "social services". Deficits in the quality and availability of data, as between the different countries of the Community, mean that this report is illustrative rather than comprehensive. This underlines the need for improvements, both in relation to identifying social exclusion and in measuring the effectiveness of policies.

Work is already under way within the institutions of the Community to develop improved indicators of social exclusion. On the basis of the argument at various points in this report, one element of this work could with profit be concerned with spatial indicators of social stress. In some countries, efforts have already been made to identify such areas by means of quantitative indicators, using data which are routinely collected for administrative purposes, in order to assess the extent to which they should be given priority in the allocation of social service resources.

As seen in Chapter 3, problems are particularly evident when seeking to assess the effectiveness of these services. As noted there, to do this properly would require data on, for example,

* the number of clients (according to different characteristics) using the different types of service and facility (differentiated according to residential/day care/home care but also, if possible, according to the provider - whether a public, commercial or voluntary organisation);

* the staffing and expenditure ratios for different facilities and services, relative to (a) the numbers of clients and (b) the numbers of the client group concerned within the local population, these data being disaggregated geographically and collected at regular intervals.

These data would, for example, enable the Observatory to examine the geographical variations in provision: and the way that some localities are much worse endowed than others in terms of the services and facilities available. They would allow comparison of the levels of provision for different client groups and changes in these levels over time; and the changing

balance between different types of provision. These changes could, albeit only crudely, then be linked to specific policy changes.

These data are not generally available, certainly not on a common cross-national basis, and in many cases not even within individual countries. Nevertheless, some data of the sort listed above are already collected on a routine basis in at least some Community countries. And the more rigorous evaluation of public policies is central to the political agenda of such countries as France and the UK. This suggests that improvements in the data available, along the lines suggested above, are by no means impracticable. It is, however, too early to guess how ready national administrative systems would be to embrace Community-wide definitions of the data to be collected. Still less certain is it that common criteria for evaluating the effectiveness of services would be acceptable; for the more that evaluation is imposed as an obligation on policy-makers, the more contested will be its parameters.

Of course, it is not with the general effectiveness of the social services that the Observatory is concerned, but rather with their effectiveness in relation to the social rights which citizens are supposed to enjoy and efforts to combat social exclusion. Here it is still more difficult to suggest indicators that would be readily available and would command general assent. Nevertheless, some more qualitative indicators were suggested in Chapter 4.

5.2. EXCHANGE OF INFORMATION AND EXPERIENCE

The reports prepared by the national experts reveal that in general, little reference is being made to experience in other EC countries as national, regional and local authorities develop their responsibilities for social services, in association with the voluntary and commercial sectors. Thus, for example, the Commission's recent efforts to promote minimum income guarantees in the various member states - something having particular importance for the four southern members, where no national schemes exist - appear to have passed unnoticed in Italy at least.

Nevertheless, an increasing range of contacts are developing, including for example:

* affiliation by national associations of local authorities to Europe-wide networks: for example, the International Union of Local Authorities, etc.;

* the establishment of European desks within some individual local authorities, concerned in part to tap funds available from the Commission in Brussels, but also to increase their awareness of new developments across the Community as a whole;

* new initiatives in cross-border collaboration: for example, as between the local authorities in Kent and the Pas de Calais;

* a growing range of voluntary sector networks at European level, not least those directed at influencing the activities of the European Community institutions.

Some of the reports also highlight specific policy debates and changes which have been stimulated by awareness of developments elsewhere in Europe:

* in Greece, the introduction of open care centres for the elderly during the 1980s; the adoption of active policies for vocational training of disabled persons; efforts to deinstitutionalise the residential care of children and to promote their social integration;

* in Luxembourg, policies towards the elderly population, drawing on the German model; and policies on social housing, drawing on the French experience;

* in Spain, the development of schemes of minimum income for social insertion, drawing on the French experience in particular (but also Belgium, the Netherlands, etc); and the development of a "mixed economy of welfare", drawing on experience in the UK, Germany and Italy;

* in Italy, legal developments in relation to drug abuse: but mainly in a rhetorical manner, with experiences elsewhere being used to justify the contending arguments in the domestic political debate;

* in the Netherlands, the Social and Cultural Report of 1990 (government-sponsored) presented a comparison of the situation in the Netherlands with other countries on a number of areas of social and cultural welfare, including reference to health trends, but mopt social services in particular.

One report, that for Ireland, examines the extent to which the major social policy documents of the 1980s make reference to developments in other European countries. It reveals that among the wider European developments thus cited are trends in morbidity, mobility handicaps, mental infirmity among the elderly, child psychiatric disorders and children in foster care. Conventions and declarations of social and human rights by international organisations have provided a further point of reference in these documents. Especially in the health field, targets and guidelines for policy used in other countries or in international bodies have been cited, for example, those of the WHO in relation to community care for the mentally ill and in relation to the prevention of drug- and alcohol-related problems. And standards of provision elsewhere, for example, the number of beds per thousand population for specific needs, have been used to assess the extent to which Irish provision meets the best international standards. Where no evaluative research is available on Irish services, corresponding research from the UK in particular is frequently employed to guide policy reform. And specific forms of practice are not uncommonly recommended on the basis of experience abroad (including, but not always confined to, the Community countries). The creation of child guidance teams, community work with delinquent children, more informal types of juvenile court.

This underlines the importance of the task which the Commission has set itself, not least in the present work of the Observatory, to promote improved mutual awareness. At the same time, however, it suggests that it may be over-optimistic to assume that simply by providing reports on developments in the various Community countries policy-makers will pay more heed to that experience, when the immediate demands of their national preoccupations seem more pressing and the relevance to those preoccupations of practices elsewhere may be difficult for them to judge. In this context, some of the reports, for example, the Greek one, stress that a disproportionate amount of the cross-national learning that has taken place has

been associated with special EC action programmes, where the financial resources offered can provide a direct stimulus to social policy reform.

5.3. MINIMUM STANDARDS OF SERVICE

Just as within individual countries there are considerable variations in the level of services provided, as a result of the autonomy of different local areas (see Section 4.5), there are major variations between countries. This raises two questions at Community level

Firstly, such variations may, arguably, raise questions of social equity, but only, of course, insofar as they are considered as arising within a single community. A single country ıay acknowledge major variations within its own territory as being inequitable; but it is debatable whether the commitment to solidarity across the Community as a whole is sufficient at this stage for cross-national variations of this sort and scale to be deemed an offence against equity.

Secondly, in some countries standards of service may be so low as to offend against the minimum standards of provision which the Community may decide to establish. However, no standards of service are worth establishing unless there are mechanisms for their enforcement. Within individual countries two mechanisms are currently being used, on which Community legislation might build. First, there is the monitoring of performance by "higher" levels of government, supervising the discharge of responsibilities by local authorities and by private agencies. Second, there is the effort to increase citizens' rights through various forms of consumer charters, by means of which the citizen can register his or her dissatisfaction. However, in using such charters, it is important not to insist on levels of responsibility on the part of the professionals concerned which are unrealistic within existing constraints of resources. It is also important to recognise that a service which is driven by consumers' insistence on their rights may be unable to meet the priorities set by professionals.

5.4. THE SINGLE MARKET AND PROFESSIONAL SKILLS

Within individual countries there are major imbalances in the distribution of social service personnel. This is, for example, the case in Italy (see Section 4.5). But with the free movement of persons which is envisaged by the Single European Act, it is at least possible that across the Community as a whole, outflows of social service professionals will denude poorer regions of the social service personnel whom they need. This is the more likely, as Community efforts to secure the mutual recognition of professional qualifications gather pace (Harris et al, 1992). And there will then, presumably, be serious consequences for the levels of social service that are available in those regions and hence for the ability of citizens living their to make a reality of their social rights.

Of course, it is not only in relation to social service professionals that this threat arises. The same goes for health and education professionals, as well as a wide range of other skills. But for the Community institutions to take any initiatives in this regard - in short, to intervene

in manpower planning and distribution - would require a major change in the political climate at Community level. The most that currently seems likely is renewed efforts to enhance the training infrastructures of the poorer regions, for example through the Human Capital and Mobility programme of DGXII.

REFERENCES

A BRUTO DA COSTA (1987), Contextual Paper on Poverty on Portugal, University of Bath, Bath.

A CARBONARD (1979), Povert... e classi sociali. Per la critica delle ideologie sui processi di pauperizzazione, F. Angeli, Milan.

D CASADO (1992), "*Information on Social Services in Spain*", in Munday (1992).

Council of the European Communities (1989), "*Resolution of 29.9.89 on combating social exclusion*" (89/C277/01), Official Journal of the European Communities, C277/1, Brussels.

E FASALO (1992), "*Information on Social Services in Italy*", in Munday (1992).

R HARRIS and A LAVAN (1992), "*Professional Mobility in the New Europe: The Case of Social Work*", Journal of European Social Policy, Vol 2 No 1, pp 1-15.

A JAMIESON (1991), "*Community Care for Older People: Some European Experiences*", in G Room (ed), Towards a European Welfare State?, School for Advanced Urban Studies, Bristol.

A JAMIESON and R ILLSLEY (1990), Contrasting European Policies for the Care of Older People, Avebury, Aldershot.

R LANDWEHR (1992), "*Information on Social Services in the Federal Republic of Germany*", in Munday (1992).

O LEWIS (1962), Children of Sanchez, Secker and Warburg, London.

SEEBOHM (1969), Report of the Committee on Local Authority and Allied Personal Social Services (Cmnd 3703), HMSO, London.

M J MILLER (1981), Foreign Workers in Europe: An Emerging Political Force, Praeger, New York.

D LUYTEN (1991), "*Niet alle armen zijn gelijk voor het OCMW*", in -Tijdschrift voor sociologie, Vol 12, No 3-4, pp 415-439.

P MOSS (1990), Garde d'Enfants dans la Communauté, Européene 1985-1990, Commission of the European Communities, Brussels.

J MOSTINCKX (1992), "*Social Services in the Flemish Community of Belgium*", in Munday (1992).

B MUNDAY (ed) (1992), Social Services in the Member States of the European Community: A Handbook of Information and Data, University of Kent.

National Council for the Elderly (1988), Caring for the Elderly, Dublin.

M PIJIL (1992), "*Information on Social Services in the Netherlands*", in Munday (1992).

N E RAMBOEJ (1992), "*Information on Social Services in Denmark*", in Munday (1992).

G ROOM et al (1992), Observatory on National Policies to Combat Social Exclusion: Second Annual Report, European Commission, Brussels.

A TOSI (1989), "*Disuguaglianze nell'accesso ai servizi sociali*", in Ranci Ortigosa E (ed), Welfare State e politiche sociali in Italia, Milan, Angeli.

A WALKER (1991), Social and Economic Policies and Older People: EC Observatory First Annual Report, European Commission, Brussels.

W J WILSON (1985), "*The Urban Underclass in Advanced Industrial Society*", in P E Peterson (ed.), The New Urban Reality, Brookings Institute, Washington DC.

Women of Europe Newsletter (1993), No 31, January-February, Commission of the European Communities, Brussels.

WHO DOES WHAT ?

COUNTRY	NATIONAL GOVERNMENT	REGIONAL GOVERNMENT	LOCAL GOVERNMENT	OTHERS ACTORS RESPONSIBLE FOR IMPLEMENTS PUBLIC POLICIES	MAIN CHANGES IN THE CAST OF ACTORS SINCE 1980
BELGIUM	Minister of Social Integration	Flemish Council: Minister of Welfare, Family & Health Institutions Council of the French Community: Minister of Social Affairs and Health	Deputees responsible for provincial social care Local Councils and Public Centres for Social Welfare providing social care and neighbourhood support	NGO's (e.g. VIBOSO)	
DENMARK	The Ministry of Social Affairs	The counties are responsible for institutions for mentally and physically handicapped	The Municipalities are responsible for: - day care institutions - residential institutions - family care for children and adolescents - nursing homes -sheltered dwellings and day care centres for the elderly - home help	Private relief organisations (non-governmental organisations) run many institutions for children and elderly people, funded by the public sector	There has been a change in the social services and a move away from the big institutions in the direction of small institutions and individual solutions Support to development projects in the local community as a strategy to improve and solve social problems
FRANCE	Social security funds: social action Departments of the social security funds	General Council: general assistants Recognised mother's helps	Municipal centre for social action (CCAS)	Youth Centres Social Centres Old people's homes Home Care Associations Crèche Associations Works Council	

COUNTRY	NATIONAL GOVERNMENT	REGIONAL GOVERNMENT	LOCAL GOVERNMENT	OTHERS ACTORS RESPONSIBLE FOR IMPLEMENTS PUBLIC POLICIES	MAIN CHANGES IN THE CAST OF ACTORS SINCE 1980
GERMANY	Federal Ministry for Family & the Elderly	Corresponding Ministry at Länder level (structure varies from State to State)	Department for Social Affairs (administration of social welfare &, partly, social services)	Welfare organisations	
GREECE	Ministry of Health, Welfare & Social Security: responsible for wide array of services & benefits for children & families, the elderly & disabled as well as public assistance and social housing		Open care centres for older people (KAPI)	National Welfare Organization (EOP): operation of rural and urban community centres which provide services for children, the elderly and other groups. Greek Red Cross: help at home programme	KAPI appeared Private sector homes for the elderly increased dramatically
IRELAND	Department of Health: overall responsibility for policy Department of Social Welfare: responsible for the Community Development Programme (grants to approximately 20 projects) National Social Service Board: advice to & development work with voluntary bodies; accreditation of & backup to Community Information Bureaux Department of Justice: responsible for welfare policy relating to offenders; welfare service connected with courts & prisons	Health Boards employ social workers & administer statutory welfare services, e.g. in relation to childcare		A very wide range of national, regional and local groups get State funding for services provided. they can be differentiated as follows: a) Religious Orders and other voluntary bodies which run residential facilities b) National bodies concerned with specific problems e.g. Irish Society for the Prevention of Cruelty to Children	Assumption of role in relation to community development projects by the Department of Social Welfare. The establishment of the Combat Poverty Agency in 1986

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IRELAND	Combat Poverty Agency: remit includes interest in community development Legal Aid Board: provides legal aid in civil cases to low income applicants			c) Regional (e.g. city-wide) & local bodies providing services to specific groups e.g. aged, families under stress	
ITALY		Regional framework laws	Childcare services: day hospitals Home help services for the handicapped, drug addicts, mentally ill, etc	Voluntary associations & cooperation within local public funded contracts	Increased role of voluntary associations & cooperation after 1991 and 1992 laws
LUXEMBOURG	Ministry of the Family and Social Solidarity		Local authorities	Associations	
NETHERLANDS	Ministry of Welfare, Health & Cultural Affairs	Department of Welfare of the provincial government is responsible for the planning of homes for the elderly	Local Government is responsible for developing and implementing policies in the area of social services & neighbourhood support	A large number of local organizations in the field of welfare are subsidized by Local Government but have great autonomy	On a national level the District Nursing & the Home Help organizations merged in 1991 The development & implementation of policies in the area of Welfare has been delegated to Local Government during the 80's The financing of Home Help & District Nursing organization is part of the Exceptional Medical Expenses Act

COUNTRY	NATIONAL GOVERNMENT	REGIONAL GOVERNMENT	LOCAL GOVERNMENT	OTHERS ACTORS RESPONSIBLE FOR IMPLEMENTS PUBLIC POLICIES	MAIN CHANGES IN THE CAST OF ACTORS SINCE 1980
PORTUGAL	Ministry of Employment & Social Affairs: Directorate General of Social Action	Regional Social Security Centres (RSSC)	Local services (branches of RSSC)	GNO's (e.g. "Misericordias") Other Government departments (health administration, social action in various Ministries)	Creation of the Directorate General of Social Action (1991) Community development programmes involving several institutions (e.g. Emergency Plan for Setobal district, support actions for people from Timor, support actions for refugees, projects to combat poverty)
SPAIN	Promotion Coordination Concerted Plan for Basic rendering Social Services from 1989	Total competence Art. 148, 1, 29	Promotion Management of social services in towns of 20,000 inhabitants or more		
UNITED KINGDOM	Department of Health (personal social services policy)	Equivalent Government depts. for Scotland, Wales and N.I.	Local Authority S.S.D.s (purchasers & managers of services)	Private sector & voluntary sector contractors	