THE WELFARE COMPLEX
IN A CHANGING SOCIETY

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More than a century ago John Ruskin said, "Not only is there but one way of doing things rightly, but there is only one way of seeing them, and that is seeing the whole of them."[1] This is an admirable sentiment to which no one will dissent; at least not at first glance. But although professional people declare their faith in the generic, the whole, the comprehensive and the multidisciplinary—whether they are talking about diagnosis, therapy, social action or planning—they still want to specialize and to define more clearly their own professional administrative or volunteer roles. They want to be more certain about themselves and their identity in an increasingly complex society. To acquire and cultivate one small allotment of skill and knowledge where one feels somewhat more secure in the vastness of the knowable is a great comfort.

To these internal pressures are added external ones. Professional people want their identity, role and functions to be known to others, for identity and specialization are linked to status. Professional people, whether they be doctors, social workers or teachers, are preeminently people with status problems.

Can people be specialists (and thus acquire status) and at the same time see things whole? Does the generalist (who is presumed to see things whole) have a future in society, particularly in the health, welfare and community care fields? Today questions such as these are

being asked concerning the future training, roles, functions and relationships of the general medical practitioner (or personal family physician) and the family-oriented social worker. These are, in fact, two of the great unresolved dilemmas—the future of the community doctor and the community social worker. Much less concern is expressed for the future of those who find protection and status in the institution; for example, the physician in the hospital or the case-worker in the child guidance clinic. Paradoxically, the discovery in recent years of the social and psychological needs of patients and clients to receive care in their own homes has coincided with the rise of the institution as the source of status, specialization and professional power.

This trend no doubt accounts in part for the observation of the Hall Commission's report on Canada's health services: "In a world of specialists, it has become imperative to review and redefine the role of the general practitioner."[2] Society is confronted with precisely that issue. Does the general practitioner have a future? What is his place in the organizational structure of health and welfare services?

The question of the future functions and field of work of the general practitioner is a far wider one than of his relationships with the hospital and of coordination with physical medicine special-ties.[3] If he is concerned with the mental as well as the physical, with social diagnosis as well as medical diagnosis, then the more complex issue arises of his relationships with a network of personal social and welfare services: services for the deprived child and the unmarried mother; child guidance and the social services of the school; the probation (or correction) services for young people and adults; special services for the educationally deprived, the mentally sub-normal and other handicapped groups; transitional hostels and community care services for the mentally ill; rehabilitation and retraining services for the physically handicapped and an extensive and varied range of domiciliary, residential and welfare services for the aged. Many of these services—public, voluntary and a mixture of both elements—have not only expanded greatly in recent years, but have been changing in form and function. With the growth, for example, of the day hospital movement, the therapeutic mental

institution and a variety of transitional (or half-way) accommodations to cater to the health and welfare needs of special groups, the policy maker, as well as the social statistician, has great difficulty in defining correctly what is and what is not a "hospital."

This blurring of the hitherto sharp lines of demarcation between home care and institutional care, between physical disability and mental disability, between educationally backward children and so-called "delinquent" children, and between health needs and welfare needs, is all part of a general movement toward more effective service for the public and toward a more holistic interpretation and operational definition of the principles of primary, secondary and tertiary prevention.[4] On a broader plane, society is moving toward a symbiosis which sees the physician, the teacher and the social worker as social service professionals with common objectives.

The accepted purpose of the health service is to treat the individual who has some malfunction in such manner as to restore him to health, and that must involve the individual's mental, emotional and social functions as well as his physical functions.

The accepted purpose of the educational *process*, of which the educational *service* is only one part, is to promote and stimulate every individual's mental, physical and emotional capacities.

The accepted purpose of social work (and the welfare services) is to help the individual who is inadequate or disturbed to develop his ability so that he may play his part in society in such a way that both he and society are tolerably satisfied.

The health, education and social work (personal welfare) services are thus all concerned with the individual and the family, and all concerned with his mental, physical and social development. They all have in common a concern for prevention, early case-finding and early mobilization of a network of specialized services with responsibilites for therapy and treatment.

This movement in the philosophy and goals of the health, education and personal welfare services, expressed in recent developments in the aims and functions of the services themselves, does present the professional worker, as well as the administrator, with relatively

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greater problems of communication, coordination and collaboration. If the patient or client is not to be fragmented, then more coordination is required, thus more channels of communication and more processes of formal and informal collaboration are needed, and more easily recognizable points of access and information are required in the interests of the often bewildered and confused citizen. A new element has to be added to the professional's role in the community: the capacity to be a cooperative "enabler." The solo entrepreneurial clinical or casework role is no longer adequate by itself in many cases; someone has to enable (or to mobilize) a variety of services and agencies to come into play in the interests of the total needs of the individual and his or her family.

This is not a static situation, but is, in fact, a rapidly moving picture with changes in political and professional thinking about ends and means, and with changes in the responsibilities and goals of a large variety of social organizations and agencies.

What are the effects of these new ideas and of reformulated principles of policy and action on the existing organizational structures of the health and welfare services? Can the present structures and administrative patterns absorb and put into practice the new thinking about people and their needs at the level of community action? More coordination and collaboration is essential if these needs are to be effectively met. Questions must be asked about the barriers which existing organizational structures create to prevent more coordination and collaboration. One should, therefore, ask questions about the structures and systems in which these services operate. To what extent do they encourage and enable, or discourage and prevent more effective coordination and collaboration?

Modern man has been said to be man in organizations. The work of Weber, Parsons, Simon and many others, and the empirical studies of such writers as Blau and Scott,[5] have greatly extended the knowledge of the principles and problems of organizational life. Social units (which are called formal organizations) are characterized by explicit goals, elaborate systems of rules and regulations, formal status structures, and, often, clearly marked lines of authority and communication. The particular form they may take in the social welfare field

has recently been analyzed by Donnison.[6] By their nature and constitutions, organizations tend to assume identities of their own which may make them independent of or impervious to the public they are presumed to serve. Although this tendency may be less true of the public service model than of the philanthropic model in the welfare field (because of lay democratic control), nevertheless all such organizations resist change from within. These models appear to have a built-in opposition to the internal development of a self-criticizing function. In the universities, or at least the British universities, this is known as "the conspiracy of silence." Change in goals and functions is difficult to bring about without external criticism.

One form in which the professional protest manifests itself in the health and welfare field has been described by Blau and Scott[7] and Gouldner,[8] among others. Their studies showed that organizations which were thought by professionals to be unsatifactory and which failed to offer career prospects and opportunities for professional advancement experienced a high rate of staff turnover. More movement was noted from employer to employer and from agency to agency among these organizations, and the spirit of loyalty to the organization was weak. Hughes analyzed the phenomenon of the "itinerant" professional who, being "more fully committed and more alert to the new developments, will move from place to place seeking ever more interesting, prestigeful, and perhaps more profitable positions."[9]

The problem of the "itinerant" professional is a serious one. It particularly concerns teachers, social workers, physicians and many professional and sub-professional groups upon whom the health, education and welfare services depend. High rates of staff turnover and shortages of professional skills are most apparent in poorly housed, working-class areas and in districts which contain substantial proportions of immigrants. This particular factor, which in large measure determines continuity of care, makes coordination and collaboration much more difficult, if not impossible. Yet in these areas, the slums of modern society, high quality services are most needed if levels of living and opportunity are to be improved for the poorer sections of the population, and if the new immigrants from

overseas are to be peacefully and tolerantly absorbed into society.

Because it impinges so much on the problems of coordinating services, the issue of "itinerant professionalism" raises again the question of the structure of organizations and agencies. It does so especially in those areas of the country which are poorly served with professional skills, and are underprivileged in the whole of their social infrastructure, public and private—hospitals, mental institutions, clinics, schools, social centers and agencies, clubs and so forth.

This is only one of the many factors which, in recent years, have stimulated discussion in Britain about the effectiveness of the existing structures and patterns of administration of the local health and welfare services. These are mainly, although not wholly, the statutory responsibility of elected local authorities of cities, towns and counties. These authorities have statutory duties and powers (sometimes in association with voluntary bodies) to provide and promote community care services—either in private homes or in hostels and other small, specialized institutions—for the mentally ill and subnormal; for the elderly, the chronically ill and handicapped living at home; and for the blind, deaf or mute, and those substantially and permanently handicapped by illness, injury or congenital deformity.[10]

Other statutes require these local authorities to provide for children in care and their families.[11] More recent British legislation in the shape of the Children and Young Persons Act, 1963, gave greatly extended powers to these authorities to *prevent* child neglect, delinquency and family break-up. In the health field, these authorities are responsible for maternity and child welfare, the school health services, home nursing and a health visiting service, home help services, chiropody treatment and a wide range of public health measures.

The general practitioner services are administered locally by separate bodies (Executive Councils) appointed by the Minister of Health and which have some local authority representation. The primary reason for this separation is that, when the National Health Service was introduced, the medical profession refused to be associated with elected local government authorities. This was also

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one of the chief reasons why the idea of the health center (visualized as a major instrument of coordination) has materialized in only a few areas. Most of the medical profession, although welcoming the idea in theory, failed to endorse it in practice.

The probation service for juveniles and adults, which has expanded substantially in the last few years, is another local service which is administered separately and is not under the direct jurisdiction of elected local authorities.

This brief account of the local structures of health and welfare administration (which is necessary to understand the problems of coordination) does no more than indicate a pattern of great complexity. Large numbers of voluntary organizations, local and national, also operate in many general and specialized fields of community organization, child care, welfare of the aged, the blind, the deaf and other handicapped groups—sometimes in cooperation with the local authorities, sometimes not.

The major problems of coordination—affecting case-finding, diagnosis, advice, treatment and care—arise, however, in the public sector. Though voluntary organizations play a significant role in certain sectors, community care in Britain is now a public responsibility. That was made clear by the publication of the government's ten-year plan in the health and welfare field.[12] This plan, together with another ten-year plan for hospital development,[13] envisaged, first, a relatively rapid decline in the role of the large institutions for the mentally ill and for the elderly chronically ill, and, second, a great expansion in the provision of community care services of all types.

Planning, however, is only one step. Implementation is another and coordination and evaluation yet another. Effectively translating these plans into practice depends on a number of key factors in addition to finance. Because social care to support and strengthen family life in the home and the community depends on the work of educated and trained staff, one of the key factors is the recruitment, training and provision of adequate career channels for physicians, psychologists, social workers, welfare workers, health visitors, home nurses, teachers and physiotherapists for small, specially built hostels,

day hospitals, children's institutions, occupational centers and a variety of community agencies. It is a manpower problem involving many detailed aspects of recruitment, training and professional advancement.

A second key factor is the quality of administration, a factor which many countries have tended to neglect. Perhaps too much emphasis has been placed on casework skills and not enough on administrative and "enabling" skills. The lessons of experience in Britain in recent years have shown that, to make a clear distinction between casework on the one hand, and administration on the other, is not possible in all circumstances.

The work of the National Assistance Board (prior to 1948 "public assistance") is an example of the importance of combining administrative and social work skills, backed by imaginative in-training schemes and the careful selection of interviewing and visiting officers. In 1948, Britain abolished the poor law and centralized the organization and financing of national assistance; cash aid, after an inquiry into means, for those in need—the elderly, widows, unmarried mothers, the long-term ill and other groups. Since 1948, the board has steadily decentralized the administration of this branch of social security, and now operates it for some two million persons (mostly pensioners) as a "citizen's right," not as a charity.[14] Its information pamphlet for the public now begins with the words, "What are my rights?" In decentralizing this service the board has, over the years, extended its welfare functions and now provides, on a national scale, a regular visiting service for hundreds of thousands of lonely and elderly people. As a Minister said in Parliament, "here is the foundation of an agency to which any citizen could turn in time of trouble or difficulty, of sickness, bereavement, incapacity or personal plight, a service which could call upon and coordinate other services to meet the needs of the particular situation."[15]

Concrete demonstrations of effective coordination in the welfare field do not often appear in the literature of social research. A striking example may be found, however, in the National Assistance Board's aid to elderly citizens. A report by Sorsby,[16] shows that, in its first 15 years, the National Health Service provided a 50 per cent

increase for both free inpatient work and free outpatient facilities in ophthalmology, and that during these years the incidence of blindness from cataract declined 25 per cent or more, with reductions also recorded for many of the other causes of blindness.

Though, as Sorsby comments, no direct cause and effect relationship between these two developments can be established, they are difficult to separate in one's mind. No similar substantial declines in the incidence of blindness among the total population have been recorded for any other country. Sorsby's report, therefore, may well be one of the few statistical and objective pieces of evidence in support of the proposition that a free system of medical care can improve health and prevent disability (especially for the middle-aged and elderly. The incidence of cataract among the age group of 70 and older declined about 30 per cent in 12 years).[17]

This is prevention in practice. What economic savings have accrued in the form of reduced demands for long-term care in hospitals, in institutions for the aged and blind and for community services, to say nothing of the prevention of human misery, would be difficult to compute.

One other conclusion relates to the matter of the referral of elderly people with visual problems and needs for services of various kinds and for voluntary registration on the national registers for the partially sighted and the blind. By far the highest source of reference for the older age groups—the numerically overwhelming section of the blind population—was the National Assistance Board, not the general practitioner.[18] This shows that to Freidson's ideas of lay referral systems and professional referral systems must be added a third—public welfare referral systems.[19] One lesson to be drawn from this example is that an effective welfare referral system can contribute to the application, in practice, of the idea of prevention.

In considering the problems of structure and coordination, the functions of the board in providing a regular and continuous visiting service, acting as an enabling and mobilizing agent and cooperating with other community services must be taken into account along with the work of other local organizations.

The board's officers who are in direct contact with members of

the public may be described as "welfare workers." They are not trained social workers, nor should they be, for much of their work is of routine nature. But when social work aid is needed the board's officers are often in some difficulty. To which agency or department at the local level should they turn?

At the present time, in most local government areas, trained social workers may be found in the public welfare department, the public health department, the public children's department, the housing department, the education department (all within the some local authority organization), the probation service, the citizen's advice bureau, and a variety of voluntary agencies. Social work skills in the public sector are thus divided and fragmented by administrative and statutory functions. Moreover, because most local departments are relatively small as organized units—due to the size of the population served in each local authority area—only a few trained social workers may be employed in each department. This leads to the ineffective use of trained staff, overlapping functions, difficulties for agencies (such as the National Assistance Board and the general practitioner) in locating the most relevant and accountable referral contact, a lack of adequate professional career opportunities and serious difficulties in sending social and welfare workers and administrators for training, graduate study and refresher courses when the staff unit is small.

In short, local government in Britain is burdened with too many small departments and too much "balkanized" rivalry in the field of welfare. Attempts to resolve these problems in the 1950's, particularly in relation to the children's services, through the establishment of local "coordinating committees" have not proved successful.[20] Demands for better coordination in the health and welfare fields and for more preventive work have increased, and have become increasingly urgent as public opinion has recognized the need for more trained social workers.

Like Canada and the United States, Britain is faced with a serious shortage of social workers at all levels, from the professionally equipped caseworker to the trained welfare worker. The shortage appears (and becomes) more acute because of the growth in public

demand for the expansion of existing services and for the development of new services; for example, major reforms in prison aftercare services, community care for people discharged from mental hospitals, social work services attached to schools and welfare services for immigrants.

The response to this national call for more trained staff, when viewed in historical perspective, has been impressive. In addition to an increase in the output of university schools of social work, more than 20 new two-year certificate courses in colleges and other institutions of higher education outside the university system have been established in about three years, under the auspices of a national Council for Training in Social Work. This year the enrollment in these courses will rise to more than 300, and this figure will double by 1968–1970.[21]

In recent years special fields such as child care have shown considerable improvement in the ratio of trained to untrained staff. For England and Wales as a whole, the proportion of child care staff without any social work qualifications at all has declined to 35 per cent.[22] A study of Ontario Children's Aid societies reported that 74 per cent of social work positions were filled by staff without any social work training.[23] These data may not be comparable, but they indicate in broad terms the magnitude of the problems of trained manpower.

SUMMARY

The themes of this paper must now be brought together. Social policy in Britain in the personal health, welfare and education fields is moving toward integrated community services, preventive in outlook and of high quality for all citizens in all areas irrespective of means, social class, occupation or ethnic group. Territorial welfare justice is one element in this movement; the most effective integrated deployment of community services and residential (or institutional) services is another, along with ease and simplicity of access and referral for all individuals and families and yet another

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is the recognition of the need to locate and attach personal social work services to publicly "normal" and acceptable points in the social system—the general practitioner, the school, the social security system and local government.

Britain's experience in recent years has indicated the necessity of learning how to use more effectively, and as a unity, the general and the specialized, community services and institutional services, the professional expert, the ancillary and the administrator. In the immediate future this may be more difficult to achieve than would the proliferation of a host of new agencies, projects and instruments of welfare. But in the long run it is more likely to provide a comprehensive coordinated service for the people.

The problem of organizational structure at the local level must, however, be resolved if a greater degree of coordination and collaboration is to be achieved.

Two possible broad routes to structural reform have recently been proposed in Britain.[24] One takes the form of a local authority family service department whose functions would include those of the present children's department, social work and probation services for young offenders under the age of 16, the institution of new family courts and a family advice center, and, in general, merging the services for mothers and children to provide a comprehensive family welfare service. Broadly speaking, this proposal is the expression of two primary influences: the idea of the family as the treatment unit and the prevention of child neglect and delinquency.

The second proposal is more far-reaching in terms of structural reorganization. It rejects the idea of a "family service" and argues that reform should not be based on biological or sociological criteria, such as the family, or on one element in the pattern of needs. Nor should it be oriented to delinquency. Instead, reorganization should proceed from the standpoint of the need for services at the community level, irrespective of age, family background or behavior patterns. Accordingly, this would mean the establishment of departments of social service at the local level. Such departments could embrace all the functions of existing children's departments and welfare departments, probation services for children and young

people, and substantial welfare, social service and mental health responsibilities shouldered at present by other departments—chiefly health departments. The top executive of such a department would be a chief social administrator assisted by a chief social worker whose primary responsibility would be to advise professionally on the most effective deployment of all social work and welfare skills in the local public sector.

These two proposals, and a series of variants on the same theme, have stimulated much debate. To different degrees, they both strive to more effectively use trained manpower; to encourage more preventive action; to avoid fragmentation, overlapping and lack of coordination; to provide better career structures for social administrators as well as social workers and, in general, to adapt organizational structures to allow and encourage modern ideas of community and mental health care to grow, develop and diversify.

As a result of the public and professional debate, conducted against the background of a rising tide of criticism of the small-scale, ineffective structures of local government, the national government appointed a committee of inquiry (the Seebohm Committee)[25] in in 1965, "to review the organization and responsibilties of local authority personal social services in England and Wales, and to consider what changes are desirable to secure an effective family service."[26] A similar inquiry is being undertaken for Scotland.

The Seebohm Committee's field of inquiry includes people of all ages who are the concern of the welfare services, the children's service and social work in health, education and housing departments.

At this stage, speculation about the nature of the committee's recommendations, which are expected at the end of 1966, would be useless. The committee probably will not shelve the problems of organizational structure and planning by recommending a series of coordinating committees in the health and welfare field. These have been tried in Britain and have failed.

In the ultimate analysis society may have to choose between "the sense of community" on the one hand, with which is equated small-scale and often ineffectively preventive, poor-quality services, and

larger social groupings offering better quality services and more freedom of choice for consumers, but with the recognized dangers of larger bureaucracies and professional power units. In facing this dilemma the question must be asked whether the purpose is to serve people—and many of the clients are defenseless people—or to advance the interests of established organizations and professional groups.

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