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OPTION : ETUDES BRITANNIQUES

MEMOIRE DE MAITRISE ES-LETTRES

THEME

BRITAIN A WELFARE STATE A MYTH OR A REALITY

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DEDICATION

This research work is dedicated to:

- My beloved mother Fatimata Abèbi MOREIRA who provides me with moral, material and financial support.
- My husband Ismailou Yanda LANDOU and my children Amirah, Bilkiss and Goufrane who assisted me in a certain way.

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May God bless them all.

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CONTENTS

INTRODUCTION

Britain is considered as one of the richest countries in the world. Some British people who know what Britain was like before the Second World War, may find great difficulties in coming to terms with the changes, enormous by any standards and affecting everyone in every facet of their lives, whatever their sex, age, occupation, or that favourite classification of the statisticians, their socio-economic group. The reasons are many, but high on the list is the colossal drop in significance of Britain as a World Power, and in the wealth at its disposal. Those with the greatest privilege would be affected adversely; the larger numbers in the working class might take a different view. Whatever the variation in social effects, the War of 1939-45 ended forever Britain's lofty position in world affairs.

So, the Welfare State was introduced. But, it hasn't quite worked out like that. What has gone wrong? Why can 22 per cent of children in Britain live below the poverty line? How can 15 per cent of the families in the entire country be in the same state of depravation?

Britain's system of health care leaves many of the elderly inadequately treated, even subject to rationing, with cancer care less affective than in other comparable European countries. Patients may wait for extended period for appointments and even longer for treatment. Many with Retirement Pensions are outraged at the proposed increase, a handful of coppers, yet they paid for their pensions. Other sources of concern for older citizens are the need to pay for services they feel should be provided by the State, or being sent out of hospital, often to live alone, within a few days of major surgery. These complaints are not new. In 1962, the Porritt Report drew attention to the problems of elderly patients in District Hospitals, although the reason given, 'that they were blocking beds' does not suggest the concern was solely for them.

The Report on Community Services in the 1970s expressed "disappointment" at some authorities inability to provide adequate services for the aged, a view repeated frequently ever since.

The Welfare State has not lived up to its promises, it has not eliminated poverty and the NHS has clear deficiencies in some areas.

Can the economy of Britain be so poor that they simply do not have money?

The last question seems to be answered by the simple fact that, in spite of all the problems, and the loss of old established industries, ship building, steel and coal, Britain is still the fourth largest economy in the world. Much is due to invisible earnings, providing few real jobs to replace the countless thousands in employment, many of whom were certain they would be in work for life. The service industries have now taken over, including the Welfare State itself, employing more than one million people in the NHS, substantial numbers in Social Security and in other Government Departments.

If this is a highly complex problem, as it undoubtedly is, are there any lessons to be learned?

Our study will take into account the different aspects of the British Welfare State described above. Firstly, we'll analyse the hindering of British welfare as far as social services are concerned : health, housing, education…; secondly, we'll deal with the Welfare State as a reality, always taking into account the management of the social services in Britain. But, first of all we'll analyse the 'two edged knife' industrial revolution which is an important element in Britain's wealth and its social consequences.

This research work is divided into three parts for its best understanding:

-Research contents and framework and the literature review.

-Hardships and challenges.

-Government's efforts to assume Britain's welfare.

PART ONE: INTRODUCTION TO THE STUDY.

Chapter 1: RESEARCH CONTENTS AND FRAMEWORK.

1.1. Statement of the problem

"Britain, a welfare state: a myth or a reality", is not a topic chosen at random. This choice comes from the information I have got about Britain. So, there is a need to clarify or lay more emphasis on the British people's conditions. As Britain is one of the world's richest countries, it may be considered as a paradise; but it is a mix of all (poor and rich, educated and non-educated…). The British people's situation has changed with the implementation of the "welfare state".

My core focus for this research work is to shed more light on the "welfare state" in Britain and show whether it is a myth or a reality.

1.2.Purpose of the study

I cannot deal with this research work without pointing out what a "welfare state" is and how it has affected the British people's life. This study aims at providing a deep understanding of the British "welfare state" before and after 1948.

Another goal of my study is to find out whether a "welfare state" implemented in Britain is a myth or a reality.

Thus, my research work will help to find solutions to the questions raised by the actualisation of the "Welfare State".

1.3.Significance of the study

Britain, an important country, had its own problems. This led to the implementation of the "welfare state" in Britain. This situation shows that investigating on this topic: "Britain, a welfare state: a myth or a reality" can help understanding more about the British "welfare state".

This study is significant in the sense that it will allow people to know more about Britain and its population's conditions. It will be about health, housing, and other social issues (education, food, employment…).

1.4.Scope of the study

We cannot achieve this research work without taking into account the scope of the study; that is the limitation of our study.

This research work is not intended to make an overall study of the topic. So, my work is to investigate on some aspects of the British "welfare state" and their consequences on the British people. Thus, I will focus my work on health, housing and other social issues (education, needs, unemployment, inequalities…)

1.5. Methodology of the study:

This section describes the methodology I have used to collect data in the course of my investigation. It has to do with the research instruments and the procedure of the data collection.

In fact, to collect reliable and truthful data, I have read some documents which give information about the British welfare state and all its aspects. I have been able to understand more about this British welfare state by exploring the concept of welfare state and some of its identifiable aspects.

I have also used the internet because nowadays, the ICT (Information and Communication Technologies) are one of the reliable sources of information and all sorts of research work can find a little solution from the internet, even if some of the documents found on the internet must be deeply analysed and coherently interpreted in order to have an accurate point of view in this work.

So, in order to deal with my topic more efficiently, I have first read some literary articles which give information about Britain, especially about the welfare state with all its aspects. Besides, internet has also played a great role since I've got useful information through it to develop my topic.

Chapter 2: **LITERATURE REVIEW**

In this chapter, we are going to clarify the concept of “welfare state” and have a look at the historical background to show how Industrial Revolution in Britain influenced British people’s life ; thus the “welfare state”.

According to Cambridge International Dictionary of English, a “welfare state” is “a system of taxation which allows the government of a country to provide social services such as health care, unemployment pay , etc…. to people who need them”. So if a person is on welfare, it means that he is receiving financial help from the state because he is poor or he has not been employed for a long time.

After the implementation of Industrial Revolution in Britain, some British people faced some problems in their daily life. To find solutions to these problems, the government created the “welfare state” in Britain.

But how did the Industrial Revolution occur?

During the nineteenth century, the United Kingdom, like most of the European and American nations, was touched by a technological phenomenon: the Industrial Revolution. This revolution touched especially the textile and the metallurgy. Factories were built to improve the production, employing more and more workers. The Industrial Revolution caused technical and agricultural transformations and the workmen underwent several transformations of their work. It is based on light industry (textile), raw materials (coal), an energy source (vapor), means of transport (railroad), heavy industry (iron and steel industry).

In addition, other domains also benefit from the new techniques of work and machines. For example, we have:

-energy: use for a calorific mineral energy;

-Natural resources: abundance of raw materials;

-demography: population grew without being slowed down by a lack of subsistence;

-mechanical energy replaced human and animal energies;

-transport: the railroad connected the great centers.

In sum, this phenomenon of Industrial Resources increased the number of employment because even if the machines replaced the hands of the farmers, they did not remove them.

But the Industrial Revolution does not have only positive aspects. Negative aspects also were observed. For example as life expectancy and birth rate increased, famine was at the gate. There were deep inequalities within the system. The workers were the victims of the economic liberalism as they were not protected by a social law and they simply worked to increase the capital of their employers. So, the 19th century attended the birth of a revolution the slogan "property and happiness for all" was a mere illusion. The workmen were ill-treated. Then, there were two classes in the proletarians in opposition to the capitalists. Although most of the wealth passed through their hands, proletarians had hard life. Their wages were miserable (2 to 3 livre sterling per day) and less for the women and children (0, 75 to 0, 90 livre sterling per day). They had bad living conditions and they were unfed thus in bad health. Some of them took refuge in alcohol and deprivation. There were also problems of housing and health because of social exclusion. They don't have access to basic human necessities (education, health, shelter, food …..) because of their limited resources.

To sum up, we can say that the Industrial Revolution in Britain hadn't improve the living conditions of the poor but inversely, reinforced the emergence of poverty in the lower class. Poverty has risen since then and is still a present difficulty in Britain. Nearly one in ten Britons has experienced conditions of absolute poverty without human necessities such as enough food, safe drinking water and proper sanitation, according to a report from **Bristol and London University**. A recent survey for the **Joseph Rowntree Foundation** estimates that a quarter (25 percent) of Britain's population is poor.

As far as children are concerned , many of them are living in poverty than in any other European Union country except Italy, with members having trebled in 20 years, according to UNICEF, the United Nations Children's agency, "one in five children lives in poverty", says UNICEF. In a report published in June 2000, Britain came 20th out of 23 countries in a legal table of relative poverty.

Poverty is more common for women than for men as far as adults are concerned, children are even more likely to be in a poor household. Unemployed households are the most likely to be poor, followed by lone parent families but the greatest number of the poor continue to be the elderly. (See the table below).

The bottom line: People in poverty by personal, economic and family status. 1996-7, UK			
	Total Number	*Proportion Poor*	*Number in Poverty*
Adult Women	*22.2m*	*24%*	*5.3m*
Children	*13m*	*35%*	*4.5m*
Adult Men	*21.1m*	*20%*	*4.2m*
Elderly	*9.8m*	*31%*	*3m*
Lone Parent Family	*4.3m*	*63%*	*2.9m*
Unemployed	*4.6m*	*78%*	*2.3m*
All		*25%*	*14.1m*
Note: Poverty defined as below 50% average income after housing costs. *Source: Department of Social Security, 1998.*			

Statistics showing which groups are more affected by poverty

To conclude, we can say that poverty is a reality in Britain and as a matter of fact, it must have an incidence on the populations' health and the British global health system.

Now, let's move to the second part of this work which is entitled hardships and challenges.

PART TWO: HARDSHIPS AND CHALLENGES

Chapter 3: HEALTH AND HOUSING

3.1. Health

There are many definitions of health. They include:

- Cultural definition: health is a standard of physical and mental well being appropriate to a particular society;
- Normative definition: health is a fixed level, or an ideal physical and mental state;
- Functional definition: health is a state of being necessary to perform certain physical and mental activities.

Health depends on a number of factors, including biological factors, environmental factors, nutrition and the standard of living. In other words health can be seen as a function of welfare.

Considering these factors, it appears that the differences between the poor and the rich, as far as biological factors, environmental factors nutrition and standards of living are concerned, are fundamental enough to lead to many inequalities in the British health policy.

3.1.1. The development of health care in Britain

Medical care in the nineteenth century was principally private or voluntary. However, sickness was a primary cause of pauperism, and the POOR LAW authorities began to develop 'infirmaries' for sick people. The number of infirmaries grew very rapidly after the foundation of the Local Government Board, because of the influence of doctors.

The demand for the infirmaries was at first resisted by a deliberate emphasis on the stigma of pauperism, of which the main legal consequence was the loss of the vote. Few people who became paupers had the vote but after the extension of the franchise in 1867 and 1884, the numbers increased dramatically. In 1885, the law requiring people to be paupers before using the infirmaries was abolished.

Prior to 1948, health services were mainly based on three sources:

- charity and the voluntary sector;
- private health care. Hospitals were fee paying or voluntary; primary care was mainly fee-paying or insurance-based;

- the Poor Law and local government. Poor Law hospitals were transferred to local government by the 1930 Poor Law Act.

These were unified when the National Health Service (NHS) was formed in 1948.

3.1.1.1. The National Health Service (NHS) in principle

The NHS is seen by many people as the core of the welfare state. People receive health care as a right. There is no right to health care on demand. The principal rights are a right to be registered with a general practitioner (g.p.), and the right to be medically examined. This generally means that a g.p. must visit a patient on the list who makes a request, though it has been accepted that examination at a distance may be feasible. There is no formal right to receive any treatment. This is within the discretion or clinical judgment of the doctor.

The NHS is supposed to protect all citizens but access to health services depends on registration with a general practitioner. The initial idea was that no-one should be deterred from seeking health services by a lack of resources; but charges were first introduced by the Labour government in 1950. Then, they were substantially increased by the Conservative government after 1979 and the 1988 Act removed free eye tests.

The NHS does ration resources according to priorities. Not only are there not regular checkups for everyone, but also there are long waiting lists, and people with quite serious needs – like those from the 1950s onwards needing renal dialysis – may die, because the cost of treatment is greater than the NHS is ready to bear. Half of the admissions in hospitals intervened after a waiting time of six months at least to three months.

The NHS inherited a misdistribution of resources, especially in London where the main hospitals were concentrated in the centre of the city. London's lack of adequate primary care coverage and over-reliance on hospitals for treatment has created recurring problems. The Labour government in the 1970s attempted to redress the balance by transferring resources from hospital care to primary care, limiting the growth of better served regions, and favouring the development of some underlined specialties, like medicine for the elderly. This led to hospital closures. The policy was continued by the Conservatives in the 1980s.

Complaints about the NHS tend to the focus on the problems of hospitals: waiting lists and lack of spare capacity in response to spending controls.

3.1.1.2. The organisation of the NHS

Initially, the NHS had a tripartite structure,- hospitals, primary care and local authority health services -. In 1974, a unified structure was introduced, with three main levels of management, at Regional Area and District level. The 1974 reorganisation led to a great deal of disruption, and was heavily criticized. Following political disagreements, Area Health Authorities were abolished in 1982 throwing out of the window ideas like local integration of services and co-ordination with social services authorities.

In the 1980s, **Enthoven** made an influential criticism of the NH, arguing that it was inefficient, riddled with perverse incentives and resistance to change. The reforms which followed were based in the belief that the NHS would be more efficient if it was organised on something more like market principles. Enthoven argued for a split between purchaser and provider, so that Health Authorities could exercise more effective control over costs and production. The NHS administration was broken up into quasi-autonomous trusts from which authorities bought services. The role of Regional Health Authorities was taken over by eight regional offices of the NHS management executive.

In principle, the Labour government has now removed the internal market. In practice, it has retained its main elements: the purchasing role of health authorities, the provider trusts and GP commissioning, but has not succeeded to attain a uniqueness of the health service system.

3.1.2. Inequalities in health

There are clear differences in the incidence of ill health by social class. In the UK, people in lower social classes, including children, are more likely to suffer from infective and parasitic diseases, pneumonia, poisonings or violence. In addition, adults in lower social classes are more likely to suffer from cancer, heart disease and respiratory disease.

There are several possible explanations for these inequalities.

- Firstly, both ‘health’ and ‘social class’ are artificial categories constructed to reflect social organisation.

- Secondly, people who are fittest are most likely to succeed in society, and classes reflect this degree of selection.
- Thirdly, poverty leads to ill health, through nutrition, housing and environment.
- Finally, there are differences in the diet and fitness of different social classes, and in certain habits like smoking, alcohol misuse and drug misuse.

It is also important to put a stress on the way disabled persons (mentally or physically) are treated in Britain. The solutions proposed for them are often inadequate and synonymous of other problems.

3.1.2.1. Mental illness and services for psychiatric patients

Mental illness is a broad term covering a range of conditions. We can name psychoses, neuroses, behavioral disorders…

Mental illness can be seen as primarily a medical or psychological condition. However it can also be seen as social because it is identified through the behaviour of the mentally ill person. Anti-psychiatrists have argued that conditions like Schizophrenia and depression are best understood and responded to in social terms.

The main thing psychiatric patients have had in common is not mental illness (their needs differ greatly) but their experience of psychiatric treatment.

For many years, mental illness led to prolonged hospitalization, often in antiquated institutions intended to isolate mad people from the community. The main reasons for this movement have been the drug revolution of the 1950s which has made treatment possible outside hospitals; the disillusion with the role played by large institutions and the substantial increases in the relative cost of institutional care.

3.1.2.2. Learning disability and normalization

Learning disability refers to a state of delayed intellectual development. In the US it is called mental retardation; in Australia it is an intellectual handicap. Although it is sometimes associated with other conditions a high proportion of

people with severe learning disabilities are also physically handicapped, most have no physical or organic origins. As people with learning disabilities grow older, they often become sufficiently competent to function in society.

Learning disability has always been socially rejected. In the 19th century, mental deficiencies were seen as evidence of degeneracy and blamed for poverty, madness and crime. Degenerates had to be isolated from the community, which led to the incarceration of idiots, feeble minded and moral defectives, in large isolated mental institutions.

The principle of normalization was supposed to develop as reaction to these dehumanizing policies. There are several different formulations, remained vain, including:

- promoting independence and autonomy;
- making it possible for people with learning disabilities to have an ordinary life;
- providing the choices and opportunities to people with learning disabilities as everyone else;
- accepting and valuing what people with learning disabilities can do.

3.1.2.3. Physical disability

Physical disability is not one problem, but a whole range of different kinds. It includes people who have lost limbs, who are blind or deaf, who have difficulty moving or walking, who are unable to sustain physical effort for any length of time, and so on. The treatment of disability as if it was a single problem may mean that disabled people receive insufficient or inappropriate assistance. The problems that disabled people have in common are not so much their physical capacities, which are often very different, but limitations on their lifestyle. Income tends to be low, while disabled people may have special needs to be met. Socially, disabled people may become isolated, as health declines, they struggle to manage on the resources they have, and they may be socially excluded.

The World Health Organization identifies three elements in disability:

- problems in bodily function or structure, which they used to call impairment;
- problems relating to activities, or disability;

- problems related to social participation, which they called handicap.

Some groups of people with disabilities have objected to the idea of handicap and prefer to talk of a social model of disability, understanding disability in terms of the social norms and expectations which shape the experience of people with disabilities.

In Britain, as in many developed societies, most disabled people are old. Policies tend to be focused on younger groups because younger groups are politically more active and disability in old age is seen as normal. But this seems an inequality, considering that in the old age, people still have some needs that stay unmet.

There are major inequalities in access to health care according to social class. Generally, people in the worst health, the poor, receive the least services and as a matter of fact, have very bad living conditions.

3.2. Housing

Housing policy is usually analysed in economic terms, as a form of market. In theory, markets lead to efficient allocation through a complex process of matching supply and demand. This depends on competition, good information, the existence of multiple suppliers and the existence of multiple purchasers. In housing, this theory has limited application. **Barlow** and **Duncan** point to:

- market closure: Housing production and finance are dominated by a few major players;
- the impact of space: Location is acutely important in the housing market; there cannot, because of it, be perfect information and full and free competition;
- externalities: Housing both affects the environment and is affected by it;
- credit allocation: the housing market is paid for mainly by borrowing, which has to be based on predictions of future value. It is very unlike the market for food;

- uncertainty: because the future is uncertain, so is the housing market. Regulation and intervention are important to reduce uncertainty;
- market volatility: Prices are dominated by a limited part of the market - those who are buying and selling property at any time;
- the problem of meeting need: if profitability is the only consideration, people will be left with needs unmet.

Most obviously, the British have many housing problems as deprivation, homelessness that the urban policy doesn't always succeed to solve.

3.2.1. Housing Problems

In most of Europe, the most basic problem is a shortage of adequate housing. This statement may seem strange, because of the crude surplus of houses over households in Britain. The apparent surplus includes, however, large apparent, large numbers of properties which are unfit to live in. when these are excluded, the result is a net shortage. This does not take account of other reasons for shortage like second homes, housing in the wrong place or the need for vacancy surplus so that people can move house.

The effect of having too little housing is that some people are left out. Because housing operates in a market, the people who are most likely to be left out will be those who have least resources. They cannot obtain accommodation or have to live in unfit accommodation. The shortage also leads to increasing prices, creating problems in the supply of affordable housing and consequently, homelessness.

3.2.1.1. Homelessness

Homelessness is a complex problem; the circumstances of homeless people vary greatly. At root, though, the reasons for homelessness come down to four main issues:

- Shortages of housing: in the 1900s, there were not enough places for people to live; housing is mainly allocated by the market, those who are excluded will generally be the poorest people.
- Entitlement to land: people squat rather than being homeless. Squatters usually build temporary shelters at first, but over time squatter settlements are built up and the housing on them becomes more established.
- Entitlement to housing: If people are not entitled to use the housing which exists, they may be homeless, even when there is no apparent shortage. Some people are excluded because of their circumstances: street children are an example. The main reason for exclusion, however, is financial: homeless people are those who cannot afford the housing which is available.
- The personal situation of homeless people: Homelessness is often attributed to the characteristics of the homeless person, such as alcoholism and psychiatric illness or to the social situation of homeless people, such as unemployment and marital breakdown. People in these situations only become homeless if they are excluded from housing or do not have enough resources to secure alternative housing.

The **Breadline Britain surveys**, identifying what people thought of as essential, came up with answers like a damp free home, heating, indoor toilet, the use of a bath, home decoration, having enough beds and refrigeration; the last two depending on space.

Deprivation is often concentrated. Slum estates occur in both the private and the public sectors. In the private sector, poor people are brought together through the magic of the market; those least able to exercise choice end up in the places least to be chosen. The same is true, to some extent, of the public sector. Where applicants for social housing are allowed a choice, the people most able to exercise that choice are those who have the highest incomes and the best housing previously. They are the ones who can wait for a better offer. Social

segregation by housing officers has contributed to this process in the past, but it equally happens in the private sector where this has not happened.

However, deprivation in Britain is not only concentrated. Most poor people do not live in poor areas and most of the people who live in these areas are not poor.

3.2.1.2. Housing and deprivation

The Breadline Britain surveys identifying what people thought of as essential, came of with answers like a damp free home, heating, indoor, toilet, the use of bath, home decoration, having enough beds and refrigeration; the last two depending on space.

Deprivation is often concentrated. Slum estates occur in both the private sector, poor people are brought together through the magic of the market; those least able to exercise choice end up in the places least to be chosen. The same is true, to some extent, of the public sector where applicants for social housing are allowed a choice, the people most able to exercise the choice are those who have the highest incomes and the best housing previously. They are the ones who can wait for a better offer. Social segregation by housing officers has contributed to this process in the past, but it equally happens in the private sector where this has not happened.

However, deprivation in Britain is not only concentrated. Most poor people do not live in poor areas and most of the people who live in these areas are not poor.

3.2.2. Housing and urban policy

Housing in Britain is commonly classified according to tenure. The main tenures are owner-occupation, local authority housing, and private rented housing. New towns are usually included with figures for council housing, while the voluntary Housing Associations have been treated as private.

The term “urban policy” is used for a wide range of different concerns and activities. The key issues relate to:

- economic development, including local economic activity, income generation and employment policy;
- social development, including housing and neighbourhood issues, relations within and between communities, and social inclusion;
- geographical issues, concerned with spatial relationships in the city, planning, transport, the environment and the urban infrastructure.

This does not define a very distinct area of concern, and some issues, like local economic policy, are not certainly urban at all.

Urban policy has mainly been distinguished by attempts to treat economic and social issues in localised settings. The characteristic modes of work include: area-based policies, often concentrated on deprived areas within cities, joint or partnership working, drawing together a range of agencies and community work, including community education, social development and political organization.

Since the beginning of the 20th century, there has been a major change in tenure. Owner occupation has grown from 10% to 67% of the stock; private renting has declined from 90% to less than 10%; and a large social housing sector, mainly represented by council housing, grew to about a third before its reduction to about a quarter. People on low incomes tend now to be concentrated in social rented housing; the average income of council and housing association tenants is just over a quarter of the income of people who are buying houses with a mortgage.

3.2. 2.1. <u>Owner occupation</u>

The growth of owner-occupation in Britain is built on a solid legal foundation, stable finance and a history of tax advantages, particularly from the 1960s to the 1990s. The Building Societies were central to this growth. They were founded on a social, co-operative and non-profit making basis, but in the 1990s many became banks, abandoning the mutualist tradition.

Owner-occupiers tend to fall into two main groups. Those who own their house outright are mainly older people, often on fairly low incomes, who have paid off their mortgage. Those who are on higher incomes will generally invest in housing by taking out further mortgages. Whether one is in the process of buying a house or not, it is strongly related to income.

More recently, a third category of low-income owner-occupation has become more important. Policies to encourage ownership have necessarily been directed at people on lower incomes, because those on higher incomes were already buying. This expansion has led to other problems, including financial hardship when incomes are unstable, difficulty with the finance companies working at the lower end of the market, legal problems, structural problems because the houses are often inferior and vulnerability to market fluctuations, particularly since the deregulation of the market in the late 1980s.

3.2.2.2. Local authority housing

Local authority housing grew after World War I; two million houses were built before 1939, over four million more after the World War 2. Initially, council housing was intended for the working classes. The main justification for its development after 1919 was the provision of housing for general needs, but after 1930, it became focused on people displaced after slum clearance. The stigma of council housing probably dates from this period: council estates were built in locations where they would not adversely affect the values of owner-occupied property.

After World War II, references to the working classes were removed. The replacement of the housing stock, particularly through clearances, became council housing's main role, with mass building. The subsidies favoured industrial, high-rise building, though this was often more expensive than the alternatives. Quantity was more important than quality. Housing policy changed after 1970, when political support for council housing was withdrawn by the Conservatives. In the 1970s and 80s, council housing acquired a more residual

role, and is now more concerned with welfare issues and special needs. General subsidies have been progressively withdrawn; for most tenants, they have been replaced by Housing Benefit. The sale of council housing to tenants and mass transfers of stock to housing associations, have reduced the numbers. As the role of council housing has diminished, Housing Associations have been encouraged to take over the limited opportunities for development.

3.2.2.3. Private rented housing

Private rented housing declined proportionately after 1919, because the growth of owner-occupation and local authority housing took out a large part of the market. Since the 1920s, it has been cheaper to buy than to rent, and capital values have been dictated by sale to owner-occupiers. As the stock aged, it bore the brunt of clearance. The sector declined numerically from 1945 to the late 1980s.

The decline of the sector has been marked by poor standards and abused by landlords. Deregulation in 1957, intended to revitalise the sector, had the reverse effect; it facilitated the exit of landlords from the market. The Rent Acts of the 1960s were designed to protect tenants from abuse and to give them some security. The law was widely disregarded by landlords and by the courts; in so far as regulation did have an effect, it was probably to slow down the rate of decline by preventing landlords from selling. In the 1980s, the Government proposed further deregulation, seemingly a repetition of the policy of 1957. The loss of capital value in the owner-occupied market has shored up the private rented sector, because owners have been forced to let properties while waiting for prices to rise again, but this is clearly temporary.

The sector survives now principally because of limited specialist markets, such as student accommodation, the desire of some owners to have some income until they can sell at a favourable rate, and the government's subsidy of rents through Housing Benefit. There tends to be more private renting in certain areas, when there is a special market for short term lettings, such as holiday lets or for students.

3.2.2.4. Poor Housing Conditions

The problems of worst states are the problems of poverty. People who are poor live differently: they are stuck at home; more, they cannot afford enough heat to avoid damp. Rich people without young children would not have the same problems. Examples of problems in poor areas are:

- vandalism: There is inadequate play space in or outside the home;
- rubbish: It may cost money to have large items of rubbish removed;
- home maintenance: Maintenance of homes and gardens costs money for equipment, which many poor people do not have;
- lack of community facilities: Shops and facilities are not economically viable;
- empty housing: Houses are left empty because the area is unattractive. A bad house in a good area would still be taken;
- design: There is a clear connection between bad design and problems like vandalism, rubbish and graffiti;

The problems with high-rise blocks have been lack of play space, isolation, disposal of rubbish, noise insulation, reliance on lifts which are often dirty, vandalised or broken; inadequate water pressure, and insecurity because of fear of fire, building movement or crime. Changes in the use of high-rise blocks would show a much higher level of satisfaction with them by the new tenants.

3.2.2.5. Urban deprivation and the inner cities

Housing conditions in many British cities are particularly unsatisfactory; the houses are old and in poor conditions. A series of policies since the late 1960s have focused on the problems of deprivation in inner city areas. Much of the concern with the inner cities grew from an attempt to produce an acceptable racial policy. Despite this, **Rex** states that ethnic minorities have not even had a proportionate share of resources from policies for the inner cities.

The basic criticisms of inner city policy are:

- the majority of poor people do not live in the inner cities;
- the majority of people living in the inner cities are not poor;
- the definition of deprived areas has been suspect. The reason Hackney appears to be more deprived than Glasgow is that its boundaries are smaller and so richer neighbouring areas are disregarded;
- the indicators used - like car ownership - have a bias towards urban areas.

Even if the premises of area-based policies are accepted, there are major concentrations of deprivation on the edges of cities.

Housing problems like most welfare failures are correlated with other social deprivations that we'll discuss in the following lines.

This chapter deals with some social problems that are the other failures of the social policy of the United Kingdom of Britain. These problems are mainly the needs of the children, the needs of the elders and the weaknesses of the educational policy.

Chapter 4 : OTHER SOCIAL ISSUES

4.1. Social problems

A problem is social when it is socially recognised: important issues like grief and emotional distress are not necessarily social, and there may be no social policies to deal with them. Conversely, other, seemingly minor, concerns and complaints, can be elevated to the status of social problems, problems are socially constructed. People's values, beliefs and opinions are conditioned by the society they live in and people come to share many basic perceptions. This can shape the way people think about issues, and close off some options: so, child abuse is usually constructed as the result of parental abnormality, and not as the obvious outcome of rules which allow children to be beaten physically. These are the issues we are going to analyse in the following sections.

4.1.1. Social need

The idea of need refers to:

- the kinds of problem which people experience;
- requirements for some particular kind of response;
- a relationship between problems and the responses available.

A need is a claim for service.

Bradshaw identifies four main categories of need:

- normative need is need which is identified according to a norm (or set standard); such norms are generally set by experts. Benefit levels, for example, or standards of unfitness in houses, have to be determined according to some criteria;
- comparative need concerns problems which emerge by comparison with others who are not in need. One of the most common uses of this approach has been the comparison of social problems in different areas in order to determine which areas are most deprived;
- felt need is need which people feel that is need from the perspective of the people who have it;

- expressed need is the need which they say they have. People can feel need which they do not express and they can express needs they do not feel.

4.1.2. Social exclusion

The idea of social exclusion comes from France, where it was the basis for a policy of insertion or social inclusion, combining benefits with plans and agreements to integrate people into society. This policy has been widely imitated and the idea of exclusion has become one of the main concepts in the European Union, precisely in Britain.

People are excluded when they are not part of the networks which support most people in ordinary life, networks of family, friends, community and employment. Among many others, poor people, ex-prisoners, homeless people, people with AIDS, people with learning disabilities or psychiatric patients might all be said to be at risk of exclusion. This is a very broad concept: it includes not only deprivation, but problems of social relationships, including stigma, social isolation and failures in social protection.

In practice, the idea of exclusion is mainly used in three contexts:

- the first is financial: exclusion is identified with poverty, and its effects on a person's ability to participate in normal activities;
- the second context is exclusion in its social sense, which identifies exclusion party with alienation from social networks, and partly with the circumstances of stigmatised groups;
- the third is exclusion from the labour market: here, exclusion is strongly identified with long-term unemployment.

4.1.3. Unemployment

The causes of unemployment are complex. Some kinds are long term: technical unemployment happens when people's skills are made redundant. Some are medium term: cyclical unemployment happens because there is inadequate demand to keep production going. Some are short term: frictional

unemployment happens because people change jobs or locations. Seasonal work, casual employment and sub employment are patterns of work which lead to people being employed only for short periods at a time.

Exclusion from the labour market takes many forms: some people can opt for early retirement, further education or domestic responsibility and others cannot. If more poor people are unemployed in UK, it is not just because they are more marginal in the labour market; it is also because they have fewer choices, and because people who become classified as unemployed are more likely to be poor. The unemployment figures are an artifact; economic analyses which are based solely on the formal unemployment rate are generally misconceived.

Unemployment in the UK has fallen considerably since the peak at the end of 1992. At the end of the 1990s, 1.82illion people were unemployment, 6.3% of those in the labour market. Some 539,000 people had been unemployed for more than a year, of which 339,000 had been out of work for over two years. The unemployment rate for those aged 18-24 was 11.9%, almost double the overall rate of unemployment. In total, the Labour Force Survey (LFS) identified around 7.6 million between 16 and 59 (for women) or 64 (for men) who were classed as economically inactive, of whom almost 2,4million indicated that they would like a job.

4.1.4. Old age

There are increasing numbers of elderly people in Britain as in many countries of the developed world. Older people represent the fastest growing section of the community. The proportion of the population aged 75 and over, rose from 5% in 1971 to 7% in 1990s. Many have no problems, but there is a risk of increasing dependency. The main reasons for their dependency are:

- sickness: the health of old people is often poor, not simply because of old age, but also because diet, housing, occupation and lifestyle in previous times have not been conducive to good health;

- physical disability: At least a third of people over 75, probably more, can be classified as disabled. The single most common cause of disability seems to be arthritis; the main single reason for ill-health is probably smoking;
- mental impairment: Dementia is believed to affect about 5% of the elderly population. Poverty: Poverty is, fo some, the result of an extended period on low incomes; for others, simply a continuation of previous circumstances.

  In general, the older a person is, the more likely these problems are to occur. Other problems may include : isolation, as friends and families die or move away, bereavement, when spouses die and housing; in effect, old people often live in older housing which may be deteriorating and the problems of care takers: many old people are looked after by women who are themselves ageing.

Another category of people which should be cared for is the children, but we observe a situation where many of their legitimate needs remain unmet.

4.1.5. The needs of children

British children have the same human needs as everyone else, like material security, social contact, and personal development. But they also have particular needs related to their development. **Mia kellmer Pringle** identifies these as needs for love and security, new experiences praise and recognition, and responsibility.

In large part, children's needs are seen as dependent on their parents. The United Nations Declaration of the Rights of the Child declares:

> The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and in any case in an atmosphere of affection and of moral and material security."

So when parents are rich, children are well treated, conversely, the needs of children are treated as a social issue when families fail to meet them either because the family itself is a source of problems (children are then neglected and abused) or because the family is unable to make provision; in this case, children live in poverty and lack of the minimum: food for the body and also for the spirit: education.

4.2. Education

There are several types of explanation for the origins of educational disadvantages in Britain:

- some writers take the view that as intelligence is largely genetically determined, no amount of education is likely to make a difference in achieved performance;
- poor educational attainment is sometimes attributed to upbringing. Generally, most children of disadvantaged parents are themselves subsequently disadvantaged;
- material deprivation affects schooling through poor health, lack of resources (like books and toys) and lack of facilities (like a quiet space for study). Family size and environment can also affect the degree of stimulation a child receives and so his development;
- disadvantages arise sometimes from the failure of schools to respond to needs. Problems include low resources, limited curriculum, and low teacher expectations, and these are reinforced by streaming, the restrictive examination system, and high teacher turnover. Despite the importance of home background, good schools can make a difference;
- structural theories relate educational disadvantage to the structure of society. Class disadvantages and poverty are reflected in educational attainment because of the combination of home and school factors.

4.3. Social inequality

Inequality is not difference. Saying that people are unequal is saying that some are disadvantaged relative to others; social inequality is disadvantage in a

social context. The main inequalities in the British society are class, gender, race and inequalities in income and wealth.

Inequalities are usually represented in one of three patterns:

- hierarchical inequality: Inequalities stretch from the top to the bottom, with everyone ranked in a relative position. This is the main pattern of inequality in income and wealth;
- stratification: People are ranked in groups, set at different levels. This model is mainly used in discussions of class and gender;
- social divisions: Societies can be seen as almost divided between groups: black and white, men and women, rich and poor. A society which was genuinely divided would not be a society any more, but the image of division is a powerful one: the 19th century politician **Benjamin Disraeli**, for example, wrote of the rich and poor as 'two nations'

There are many basic inequalities in the British society and they are reinforced by the experiences individuals face and what they become – after being educated and being employed – independently of what they were – poor can become rich and rich can become disabled in their old age -. Anyway, the challenge of the welfare state which is a happy world for everyone is difficult to assume; but the second part of the document describes to some extent, the British administrative authorities' efforts to build such a wonderful day by day success.

PART THREE: GOVERNMENT'S EFFORTS TO ASSUME BRITAIN'S WELFARE

CHAPTER 5: THE WELFARE STATE IN BRITAIN

5.1 Values in social policy

This section review some of the principles and values which are applies to social policy. It is difficult to give a clear account of this kind of issues without oversimplifying. None of the topics outlined here has a simple, unambiguous meaning; the concepts are often said to be essentially contested.

- **Individual and social well-being**

Well being is a multi-faceted concept: it might refer to:

- needs : the things which people must have ;
- interests : things which are good for people ;
- wants: the things which people choose for themselves.

Despite the ambiguity; some generalisations are possible: in each sense; poverty can be identified with a lack of well-being.

Individualists and economists define well-being as a poverty of individuals. Social well-being is the interests of people in groups, which is not always the same as the people within it; there are often conflicts between the interests of individual, families and communities. For example, it is generally considered to be in the interest of a nation to defend itself against attack; even where people within it suffer directly as a result. Individual and social welfare coincide because people are interdependent, social creatures, and people rely on social mechanisms like social interaction, exchange, the division of labour, and education for their personal development and well-being.

- **Solidarity**

The idea of solidarity is referred to in catholic social teaching as ‘’a firm and persevering determination to commit oneself to the common good, that is … the good of all and of each individual, because we are all really responsible for each other.’’

The basis of solidarity is mutual obligation. This is mainly expressed through reciprocity or exchange. Balanced reciprocity occurs where people make a direct return for the things they receive. Often, though, reciprocity is

generalized; there is no simple balance, but people give because they have received something in the past, or because some future reciprocity is possible. For example, parents give to children because their own parents gave to them; people support pensioners in the expectation that future generations will support them when they are pensioners. Generalized reciprocity is the norm within families, but it also occurs in mutual insurance.

Solidarity can be difficult to distinguish from altruism, but there is no reason to suppose that the motivation is unselfish. The central problem of solidarity is that it is often exclusive –confined to a special group.

- **Rights**

Rights are rules: they can protect liberties or impose duties on other people. Moral rights are rights which are backed by a moral claim; legal rights are backed by a legal sanction.

Rights to welfare can be general (applying to everyone) or particular (applying only to specific people). The welfare states of continental Europe have mainly developed particular rights, related to membership of schemes and individual rights; the model followed by the UK attempted to extend rights to everyone, on the basis of citizenship.

Citizenship is the right to have rights. **T H Marshall** called citizenship as a status bestowed on those who are full members of a community. ‘’This idea, like solidarity, can be exclusive; it can be used to deny people’s rights, as well as to include them.

- **Justice**

There are two main approaches to justice:

- The Platonic idea sees justice as what is good, right or desirable

John Rawls, for example, asserts that freedom is part of justice. If justice is about what makes for a good life, then freedom might be part of justice and so might motherhood, apple pie and good television reception.

- The Aristotelian view sees justice as a principle of proportionate action.

Social justice is basically a distributive principle: it concerns the

proportions in which people should contribute to and receive things from society. Corrective justice means that the punishment should fit the crime; distributive justice means that people should have fair shares.

Justice begins with a presumption of equality; people should not be treated differently without a reason. There may, though, be many reasons. The criteria which have been proposed as the basis for distribution are complex: they have included need, desert, contribution to society, hereditary status, and many others.

- **Freedom**

Freedom has three elements. A person must be free from restraint, to do something. Freedom is, then:

- Psychological : people must be able to make a choice ;
- Negative : people must not be prevented ;
- Positive: people must be able to act.

Individualists argue for a model of freedom where people's freedom depends on their independence. Social welfare and state intervention are seen as undermining independence, and so freedom.

A social model of freedom begins from the view that freedom depends on interdependence. To be able to act, people have to have the power to choose in society. In this model, poverty negates freedom. Social welfare empowers people and enhances their freedom.

- **Democracy**

Democracy refers to:

- ✓ a system of government. Representative democracy is a system of elected government. Democracy consists mainly of a competitive struggle for popular vote which makes governments responsive and accountable.
- ✓ a system of decision- making. Participative or direct democracy gives decisions to the people who are affected by them.

- ✓ a society where people have rights. Liberal democracy accepts majority voting only because a majority is made by the agreement of a collection of minorities.

Welfare provision has grown hand in hand democracy. **Drèze** and **Sen** claim that there has never been a famine in a democracy; they argue that this is because political rights are fundamental to the maintenance of social and economic rights.

- **The State**

The state is a general term for the institutions, agencies and procedures related to government. The idea of the welfare state suggests that social policy is mainly a governmental responsibility, though in practice, many of the functions of welfare states are undertaken by agencies beyond the government.

If governments are concerned about the welfare of their citizens (some are not), they will have some responsibilities for social protection. These responsibilities may be residual (confined to those who are unable to manage in other ways), but most states have found that it is impossible in practice to confine their actions only to support in the last resort (the model of poor law). The reasons are partly administrative (strict selectivity is costly and inefficient), but mainly political: the pressures for expansion are irresistible.

The welfare states are institutional forms of social protection, where the state has come to set the terms on which social protection is delivered. Some writers have argued that states should confine themselves to a more limited range of activity, but if the same activities can legitimately be undertaken by non-state agencies it is difficult to see why they cease to be legitimate if a properly constituted government does them.

5.2. Government of welfare

The United Kingdom is a unitary state in which central government substantially directs most government activity. However, the structure of services in Scotland, Wales and Northern Ireland differs in certain respects.

Each region has both a secretary of state and administrative department situated in central government, and its own assembly and executive, which take on the role in the region of certain central government ministries. The laws which apply in Scotland and Northern Ireland are different from those in England and Wales. The administrative structure in Northern Ireland is significantly different: personal social services are the responsibility of the Health Board - as they are in the republic of Ireland - and public housing is managed by Northern Ireland Housing Executive.

The table below presents the main British department dealing with social policy.

CENTRAL GOVERNMENT	**RESPONSIBILITIES**	**NATIONAL ORGANISATIONS**	**LOCAL GOVERNMENT**
Cabinet		Scottish Executive ; Wales office ;Northern Ireland office	Local authorities London boroughs
The Treasure	Economic policy government finance	Ireland revenue (taxation) ; tax credits and social security contributions	
Department of Health	Health care Social Services	National Health Service	
Department of work and pensions (formerly Department of social security)	National insurance Social assistance Employment	Benefits Agency Child support Agency Employment service Information Technology Services Agency	
Department of Transport, the Regions and Local Government	Local government ; Urban policy Housing		Planning ; housing ; environmental Health
Home office	Law and order Racial issues	Probation service ; Immigration service	Police Fire

		Prison	
Department of Education and Skills	Education	Higher education	Schools; Education welfare ; Learning disability (5-18)

The main government departments dealing with social policy in the UK

5.2.1. Administration of welfare

The administration of the welfare state, in Britain, has undergone two major reforms since its inception. The first phase, covering the 1960s an 1970s, saw central government reformed in order to allow the planning and control of public expenditure by the Treasure. The aims of this reform were managerial efficiency and economic planning. The effect was to create a system in which the Treasury allocated resources to departments, and departments to services.

The second phase, which has led in the 1980s and 1990s to restructuring of the civil service and the administration of welfare, has three main elements:

- The breakup of the administration into agencies, so that the efficiency of each part of the administration can be assessed individually. Examples are NHS trusts and the administrative agencies responsible for Social Security.
- The introduction of management with managers being responsible for running agencies in a business- like fashion ; this is widespread in health and personal social services.
- Quasi markets: Public services are required to act more like economic markets, with the separation of purchasing and provision of services and the introduction of competition. The trend is strongest in health and social care.

5.2.2. Local government

Local government grew, in England and Wales, from the administration of the Poor Laws. When local services for health, social assistance and education were established during the 19th century, someone had to be responsible for their delivery; the powers were given to the Poor Law guardians, and subsequently this became the core of a reformed local government system. However, local government lost many of its powers after the war – including responsibility for health, social security and public utilities - and has progressively declined in influence since. The structure of local government was reformed in the 1970s, to form two main tiers (county and district) in most of Britain; in 1996 local government was focused in a single administrative tier, though some two-tier authorities have been retained.

The UK has a highly centralised system of government, and the powers of local government are very limited. Central government exercises considerable controls over local action:

- Legal restraints: Local authorities are forbidden by law to do anything which is not expressly permitted by Parliament; local authorities who want to undertake any special initiative need to promote a private Act of Parliament.
- Advice the work of local government is increasingly regimented by central government instructions;
- Inspection and audit : councilors can be personally fined for breaching audit rules, a situation which would not be tolerated by national politicians; and
- Financial controls: despite the existence of a council tax, local government has very limited discretion in its ability to raise money, and it is not permitted to exceed central government limits. Loans cannot be taken without express sanction. Central governments can make the availability of grants conditional on compliance with their policy.

The main power local government has is one of conservative resistance, usually in the form of a failure to put central government policies immediately into effect.

At the end of the Second World War, many actions have been decided by the labour party for an actual welfare state.

Chapter 6 : THE WELFARE STATE AFTER 1948

The Beveridge Report of 1942 proposed a system of National Insurance, based on three assumptions:

- family allowances;
- a national health service;
- full employment.

This became a major propaganda weapon, with both major parties committed to its introduction. During the war, the coalition government also committed itself to full employment through Keynesian policies, free universal secondary education, and the introduction of family allowances. The Labour Government was elected in 1945 and introduced three key acts.

- The 1946 National Insurance Act, which implemented the Beveridge scheme for social security;
- the National Health Service Act 1946; and
- the 1948 National Assistance Act, which abolished the Poor Law while making provision for welfare services.

These Acts were timed to come into force on the same day, 7th June 1948. The 1948 Children Act was another important element.

The key elements of the ‘’Welfare State’’ were understood as being: Social Security, Health, Housing Education and Welfare and children (the personal social services).

Contemporary arguments emphasised the inter-related nature of these services, and the importance of each for the other. However, the administrative division between services was reinforced by reactions against the unifying and all–embracing nature of the Poor Law, which led to a strong distinction being made between income maintenance, health and welfare services.

The Welfare State was not intended to respond to poverty; that was what the Poor Law had done. The main purpose was to encourage the provision of the social services on the same basis as the public services – roads, libraries and so forth – an ‘institutional’ model of welfare. Criticisms of the Welfare State in

later years, however, were to concentrate increasingly on the problem of poverty, and debates in the UK are increasingly in tone.

Asa Briggs, in a classic essay on the British welfare state, identified three principal elements. These were:

- a guarantee of minimum standards, including a minimum income;
- social protection in the event of insecurity; and
- the provision of services at the best level possible.

This has become identified, in practice, with the 'institutional' model of welfare: the key elements are social protection, and the provision of welfare service on the basis of right.

6.1. Welfare and society

Social policy draws on sociology to explain the social context of welfare provision. If we are trying to improve people's welfare, it is helpful to try to understand something about the way that people are, and how welfare policies relate to their situation. Some writers have gone further, arguing that because welfare takes place in a social context, it can only be understood in that context. This has been particularly important for 'critical social policy, which begins from a view of social policy as underpinned by social inequality – particularly the inequalities of class, race and gender.

Societies are 'structured' in the sense that people's relationships follow consistent patterns. **Fiona Williams** has argued that social policy is dominated in practice by the dominant values of society – the issues of family and work.

6.1.1. Family policy

A range of policies are built around the idea of the ‘family’ as a man, woman and children. Examples are child benefits, education and child care. In addition, social policies are built on the idea that the man is the ‘breadwinner’, with support based on the idea that the marriage is permanent and the woman will not work. Families which deviate from the norm – for example, poor single mothers – are likely to be penalised, though there may also be anomalies in the organisation of benefits; for instance, when promiscuity is accepted and stable cohabitation is not.

- **The Normal Family**

Normal does not mean average; it means ‘’conforming to social norms’’. The ‘normal’ family consists of two parents with one or more children, but it is increasingly untypical in Britain. Several factors have contributed to this trend:

- ✓ ageing populations: which mean that increasing numbers of households consist of elderly people without children;
- ✓ the delay in undertaking childbirth, which means that more households consist of single women or couples without children;
- ✓ the growth of single parenthood;
- ✓ household fission: the tendency for households to split, because of divorce and earlier independence for children.

Social policies sometimes seek to reinforce the normal family, by rewarding normal conduct or penalizing deviant or non-normal circumstances. Rewards include subsidies for married dependants and children; penalties include requirements to support one’s family, and legal and financial deterrents to divorce. At the same time, the assumption that couples live more cheaply than single people may lead to two single people getting greater support: cohabitation rules, treating people living together as if they were married, are used to ensure equity with married couples.

- **Single Parents**

The rise in single parenthood is mainly based on three factors:

- ✓ divorce, which has been increasing as women have gained independence in finance and career;
- ✓ unemployment which is correlated with divorce, because it strains the marriage and it undermines the role of the traditional male breadwinner.
- ✓ cohabitation which effect is a statistical artifact, rather than a real change in parental status.

The position of single parents who receive social benefits has been controversial. The liberal individualist position is that if people choose to have children it is then up to them to look after their family.

The collectivist position, and to a large extent the dominant position in continental Europe, is that children are other people's business as well.

There is also a strong body of opinion which considers that the interests of the children override any moral concerns about the status of the parents.

There is no reason to attribute the rise to teenage motherhood which, like other forms of motherhood, has tended to fall.

- **Teenage Pregnancy**

Teenage pregnancy was the norm in previous generations, but it has become more common for women to delay childbearing. The reasons for the delay, and for falling birthrates, include:

- ✓ the effect of urban society on the cost of having children;
- ✓ the changing role of women;
- ✓ the economic effect of female employment, which leads to a loss of income if women leave the labour market to have children;
- ✓ the availability of contraception: the government ensures the provision of effective planning services. Free family planning services is available from GPS or family planning clinics. Clinics are also able to provide condoms and other contraceptives free of charge.

Teenage pregnancy is high when the factors above do not apply to the same degree. This accounts for the apparent association of some social problems with teenage pregnancy.

6.1.2. Work

Many systems of social protection depend on a stable work record for basic cover in unemployment, ill health and old age. Workers who misbehave – for example, by striking or being dismissed – may be penalised.

- **Patterns of Work**

The incorporation of people into the formal labour market has been central both to policies to deal with poverty and exclusion, and to the development of social protection. However, in many circumstances people are only partly integrated into the labour market. Their situation is characterized as:

- ✓ a "dual labour market", distinguishing the social position of secure employees on regular pay from others;
- ✓ "peripheral" workers, whose role in the economy is more marginal, and who are liable to displacement during economic cycles;
- ✓ "Precariousness", the role of marginal works who move between casual and part-time work and joblessness.

Economic marginality has implications for social inclusion. Unstable economic conditions lead to social instability – marginal employment is associated with family breakdown – while also reducing the level of social protection available.

- **The Role Of The Labour Movement**

British welfare system has its origins in collective and mutualist actions by trades unions, professional or occupational groups, rather than the state. It is also true that welfare developed historically at a time of social conflict, and labour organisations have had an important role in the development of policy, including Bismarck's establishment of social insurance and the foundations of the British social services. Marxists have traditionally seen the welfare state as

the outcome of measures – like insurance-based pensions in the UK – have developed despite the resistance of organised labour, and others, like the extension of rights to the poorest, have been marked by conflicts between groups.

6.1.3. Policies for equality

The inequalities which British are concerned with, concern;

- individuals: the comparison is made, for example, between rich and poor people;
- blocs in society: like women, racial minorities, old people or regions;
- segments: for example, a distinction confined to children or to women.

A policy which corrects one inequality (e.g. between women and men) can aggravate another (e.g. between rich and poor, if the beneficiaries are richer women). For example, there is a current argument in India that attempts to avoid gender discrimination between castes.

Policies for equality aim at:

- equality of treatment; this is treatment without bias, prejudice or special conditions applying to people. It is not treating everyone the same – equality of treatment in health services does not mean that everyone gets a tracheotomy;
- equal opportunity: This can be the opportunity to compete – in which case it is the same as equal treatment – or the chance to compete on the same footing as others (which may require some redress before the competition starts);
- equality of outcome: Policies which are concerned with inequalities of income or health status are generally concerned with removing disadvantage in outcome.

6.2. Social stratification

6.2.1. Class

Class is an ambiguous term, used in three main senses:

- Economic position: **Max Weber** defined class in terms of relative economic position. There are obviously economic differences between people depending on how much money they have; but there are also many other economic groups; it is possible to distinguish people, for example, according to employment status, or the kind of income they have (such as fees, salaries, and social benefits). We can also use housing tenure as the basis for different classes.
- Productive relations: Marxists understand class in terms of the economy. The main distinction in Marxism falls between those who own the means of production and those who sell their labour, but if the basic criterion is accepted there must be other classes: the petite bourgeoisie, who owns small shops and firms, or the underclass who is marginal to the labour market.
- Occupational status: Classifying people by occupational status may be useful in sociological analyses of other issues.

6.2.2. Status

Status is described as a form of 'social honour' or esteem. People's social rank is associated with their class, but the terms are not equivalent; some social roles may have high esteem but low resources (like clerics).

The receipt of welfare has often been associated with social dishonor: the classic example of this is the "stigma of pauperism", the deliberate use of shame to stop people claiming from the Poor La. The recipients of welfare are socially rejected; they are liable to be portrayed, like the pariahs of caste system, as immoral, dishonest and dirty.

Social policies tend to be concerned disproportionately with people of low status. In part, this happens because the client groups of the social services tend

to be people who already have low social esteem – the poor, disabled people, mentally ill people, single parents and so on. In part, too, the receipt of social services may carry a stigma. The principle of institutional welfare was intended to remove degrading differences in status between recipients.

6.3. Social divisions

6.3.1. Gender and social policy

Social roles, or expectations, determine the range of opportunities for women and men. Understanding gender divisions is important for social policy, partly because issues affecting women are part of the agenda which social policy must tackle, but also because many of the concerns of social welfare - like poverty, health and old age – are related to gender.

Feminist critiques of welfare have argued that social policy is strongly 'gendered'. **Jane Lewis** has suggested that, although the dominant models of welfare all assume that women are dependent on a male breadwinner, there are important variations:

- a strong 'male breadwinner' model supposes that women's incomes are secondary to men's. This is the main model in the UK;
- a modified model gives women a special status in relation to motherhood;
- a weak male breadwinner model allows for women to act as breadwinners in the same way as men.

Where assumptions are made about the position of women, this tends to reinforce women's inferior status and dependency. Where special provisions are not made, however, this tends to undermine the levels of protection which women receive when they have not earned income on the same basis as men.

6.3.2. Feminist perspectives on social policy

There are three main classes of feminist theory: liberal, Marxist and radical. They share a common concern with gender as a focal issue in social policy.

Liberal feminism emphasises the rights of women as individuals. It argues against discrimination and stereotyping, and for equality of respect and opportunity. Arguments against limits to opportunity, like complaints against women's careers, are classically liberal: they suggest that women should benefit from the same advantages as men.

Marxist feminism views the oppression of women as the result of the economic structure of society. Domestic relationships are seen in class and the relationship of the household to the means of production. **Heidi Hartmann** comments: "The 'marriage' of Marxism and feminism has been like the marriage of husband and wife depicted in English common law: Marxism and feminism are one, and that one is Marxism."

Radical feminism argues that British society is dominated by patriarchy, a structure of power in which men dominate women. Patriarchy is sexual politics whereby men establish their power and maintain control. This analysis is combined with the moral position that women should be able to live and act autonomously.

6.3.3. Immigration and nationality

Immigrants, by definition, come from outside a community; wherever social protection depends on contribution to collective welfare, immigrants are liable to be excluded. Residual income support may be available, but it is unusual for non-contributory benefits, such as benefits for disabled people, to be available directly to immigrants; Britain, as many countries have some kind of minimum residential qualification.

Much immigration consists of movements of people from poorer countries to richer ones: immigrants tend to come with relatively limited resources. Britain is among the few countries that offer immigrants – the regular ones, obviously – a full range of social protection or benefits, and in the short term this is likely to lead to disadvantage. At the same time, migrants tend to be younger and more mobile than host populations. In the longer term, much depends on the economic

niche occupied by immigrant groups, and their relative status and resources. Immigrant careers are highly differentiated. Issues of immigration overlap with racism.

6.3.4. Race and social policy

Race has no fixed meaning. Although some commentators identify race closely with skin colour, the experience of racism is not confined to colour: the groups in Europe which experience the strongest rejection are probably gypsies and Muslims. Racial discrimination refers to the deliberate use of adverse selection as a means of putting people from particular racial or ethic groups in an inferior position, but deliberate discrimination is not necessary to explain much racial disadvantage; the effect of denying access to the resources, opportunities and conditions of life available to others is to make the experience of disadvantage worse.

Although issues of race and racism feature largely in many discussions of the sociology of welfare, it is more difficult to point directly to British policies which are directly concerned with race in intention and effects as the racialised ideas behind German Nazism, or the apartheid régime in South Africa, which offered different types and standards of social services to ‘whites’, ‘blacks’, ‘Asians’ and ‘coloureds’.

More typically, policies concerned with ‘race’ are developed more obliquely. The UK Urban Programme, addressed perceived racial problems through other means. This programme was a desultory response to a notoriously inflammatory speech by **Enoch Powell**, which coded such terms as ‘inner cities’ as a euphemism for race. The effect of working in code, of course, was that the problems of racial minorities were hardly addressed by the programme.

In the following lines, we’ll determine whether the later’s position about the fact that “the NHS criticism is exaggerated” is true or not.

Chapter 7 : HEALTH

7.1. The national health service (NHS)

Health policy is dealt with the National Health Service in Britain. It provides a full rang of medical services, available to all residents, regardless of their income. Central government is directly responsible for the NHS, which is administered by a range of health authorities and health boards throughout the UK.

7.1.1. The NHS's duties:

The department of Health is responsible for national strategic planning and within that department; the NHS executive is responsible for:

- developing and implementing policies for the provision of health services;
- identifying the healthcare needs of the people;
- securing hospitals and community health services;
- arranging for the provision of services by family doctors, dentists, pharmacists and opticians;
- administering the people's contracts.

Health authorities and boards cooperate closely with local authorities responsible for social work, environmental health, health education and other services. Among the major targets, considered as failures in the first part of this document, which the Government has promised to deliver, we have:

- reducing waiting lists;
- delivering higher and more consistent standards of treatment and care throughout the NHS;
- reducing inequalities in health: promote healthy schools (for children), healthy workplaces (for adults) and healthy neighbourhoods (for older people); and improve the lives and prospects of children looked after by local authorities.

The government is also tackling premature deaths causes such as:

- coronary heart disease and stroke which is the major cause of premature death in England;
- cancers (mainly for people under 65), it's the second biggest cause of premature death, consuming nearly 7% of the NHS budget. The government improved the provision and availability of high-quality cancer services: reducing the waiting list to two weeks for cancer's complaints…
- mental illness to reduce the death rate from suicide and undetermined injury;
- accident which is known as the commonest cause of death for those under 30;
- HIV/AIDS and sexual health: up to the end of June 1998, a total of 15,565 cases of AIDS had been reported in the UK. The total number of recognized HIV infections was 32,242 of whom 84% were male. 60% were homosexual or bisexual males. The government's strategy includes: encouraging appropriate behavior change by increased targeting of sections of the population at particular risk, including homosexual and bisexual men and drug misusers; sustaining and improving general public awareness; continuing to make HIV testing facilities widely known; and continued funding for the voluntary sector;
- tobacco misuse: cigarette smoking is the greatest single cause of preventable illness and death in the UK. It is associated with around 120,000 premature deaths a year, nearly one fifth of all deaths. The largest increase in smoking rates is among teenagers, especially girls. So, actions to reduce smoking as tobacco advertising and controls promotion, especially among children and young people, are a priority.

The NHS is one of the largest employers in the world with a workforce of nearly 1 million people. They are composed by:

- the medical staff;
- the dental staff;

- the nursing and midwifery staff;
- the professional and technical staff;
- the health care assistants;
- the administrative and clerical staff;
- the ambulance staff;
- the family health services staff including GPs, dentists, ophthalmic medical practitioners, ophthalmic opticians;
- and the health service commissioners.

The NHS is based upon the principle that there should be a full range of publicly funded services designed to help the individual stay healthy. The services are intended to provide effective and appropriate treatment and care where necessary while making the best use of available resources.

7.1.2. Expenditure and finance

All taxpayers contribute to their cost so that members of the community who do not require healthcare help to pay for those who do. Some forms of treatment, such as hospital care, are generally provided free; other may be charged for.

Almost 81% of the cost of the health service is paid for through general taxation. The rest is met from:

- the NHS element of National Insurance paid by employed people, employers and self-employed people;
- charges towards the cost of certain items such as drugs prescribed by family doctors and general dental treatment;
- capital refunds from NHS Trusts;
- other receipts including land sales and the proceeds of income generation schemes.

Health authorities may raise funds from voluntary sources. Certain hospitals increase revenue by taking private patients, who pay the full cost of their accommodation and treatment.

Some 500 million prescriptions, worth almost 4,400 million pounds, are dispensed each year in England. At the end of the 1990s, an estimated 85% of medical prescription items were supplied free. Prescription charges are not paid by:

- children under 16 years or young people under 19 who are in full-time education;
- pregnant women and women who have had a baby in the past year;
- people aged 60 and over;
- patients with certain medical conditions;
- war and armed forces disablement pensioners;
- and people or families with low income.

There are also proportional charges for most types of NHS dental treatment, including examinations.

Family practitioners are self-employed and have contracts with the NHS. GPs paid by a system of fees and allowances designed to reflect responsibilities, workload and practice expenses.

7.1.3. NHS complaints system

Complaints about all NHS-funded services are dealt with at two levels. The procedures aim to resolve complaints speedily at a local level; when complainants are dissatisfied with the response at local level, a new system of review by an independent panel is an option. Patients refer complaints to the Health Service Commissioner if they are dissatisfied with the response from the NHS.

Health Service Commissioners are responsible for investigating complaints directly from members of the public about health service bodies as a result of:

- a failure in a service provided by a health service body;
- a failure to provide a service which the patient was entitled to receive;
- something that an NHS authority failed to do or did in the wrong way.

- in 1999, the commissioner dealt with 2,660 complaints about the NHS.

7.2. Health care

7.2.1. Family health services

The family health services are those given to patients by doctors (GPs), dentists, opticians and pharmacists of their own choice. They remain the first point of contact most people have with the NHS. In England, there are over 270 million consultations with GPs each year. Often the patients need no clinical treatment but healthy lifestyle counseling and preventive healthcare advice instead.

GPs provide the first diagnosis in the case of illness, give advice and may prescribe a suitable course of treatment or refer a patient to the more specialised services and hospital consultants. Most GPs in the UK work in partnerships or group practices in health centres.

Health centres provide medical and nursing services as well as education, family planning, remedial services, dental services, pharmaceutical services, ophthalmic services…

Primary healthcare teams also include health visitors, district nurses, midwives and sometimes social workers and other professional employed by the health authorities.

The two last decades have seen continued growth of the Family Health Services with long-standing government policy to build and extend these services in order to improve health and relieve pressure on the most costly secondary care sector: hospital and specialist services.

7.2.2. **Hospital and specialist services**

District general hospitals offer a broad range of clinical specialties supported by a range of other services such as anaesthetics, pathology and radiology; almost all have facilities for the admission of emergency patients,

either through accident and emergency departments or as direct referrals from GPs.

Treatments are provided for in-patients, day cases, out-patients and patients who attend wards for treatment such as dialysis.

Some hospitals provide specialist services which cover more than one region or district. These are known as supra-regional or supra district services covering, for example, heart and liver transplants, craniofacial services and rare eye and bone cancers.

Other hospitals combine specialist treatment facilities with the training of medical and other students, and international research.

7.2.3. Private finance initiative and private medical treatment

The Private Finance Initiative (PFI) was launched in 1992 to promote partnership between the public and private sectors on a commercial basis. In the health service, it involves the use of private finance in NHS capital projects for the design, construction and operation of buildings and support services. Under the legislation of 1997, 25 major hospital schemes in England, with a capital value around 2,200 million pounds, and 11 in Scotland, with a value of 408 million pounds, have been approved to proceed. The hospitals are designed, built, maintained and owned by the private sector which leases the completed facilities to the NHS. Clinical services and planning decisions are provided by the NHS staff.

Some NHS hospitals share expensive equipment with private hospitals and NHS patients are sometimes treated (at public expense) in the private sector where it represents value for money. The scale of private practice in relation to the NHS is however, relatively small.

It has been estimated that about three-quarters of those receiving acute treatment in private hospitals or NHS hospital paid beds are funded by health insurance schemes, which make provision for private healthcare in return for annual subscriptions.

Many overseas patients come to the UK for treatment in private hospitals and clinics. Harley Street in London is an internationally recognized centre for medical consultancy.

7.2.4. Personal health services

- **Rehabilitation**

Rehabilitation services are available for elderly, young and mentally ill people, and for those with physical or learning disabilities who need such help to resume life in the community. These services are offered in hospitals, centres in the community and in people's own homes through coordinated work by a range of professionals.

Medical services may provide free artificial limbs and eyes, hearing aids, surgical supports, wheelchairs and other appliances. Following assessment, very severely physically disabled patients may be provided with environmental control equipment which enables them to operate devices such as alarm bells, radios and televisions, telephones and heating appliances. Nursing equipment may be provided on loan for use in the home.

Local authorities may provide a range of facilities to help patients in the transition from hospital to their own homes, including the provision of:

- equipment;
- help with cleaning, shopping and cooking;
- care from domestic help workers;
- professional help from occupational therapists and social workers. Voluntary organisations also provide services, complementing the work of the statutory agencies.

- **Hospices**

Hospices or palliative care is a special type of care for people whose illness may no longer be curable; it enables them to achieve the best possible quality of life during the final stages. The care may be provided in a variety of

setting: at home, in a hospice or palliative care unit, in hospital or at a hospice day centre.

Hospice focuses on controlling pain and other distressing symptoms and providing psychological support to patient, their families and friends, both during the patient's illness and into bereavement.

Palliative care was first developed in the UK in 1967 by the voluntary hospices and continues to be provided by them in many areas, but is now also provided within NHS palliative care units, hospitals and community services. They mostly help people with cancer, although patients with other life-threatening illness are also cared for. There are also several hospices providing respite care for children from birth to 16 years old.

- **Parents and Children**

Special preventive services are provided under the NHS to safeguard the health of pregnant women and of mothers with young children. Services include free dental treatment, health education, vaccination and immunisation of children against certain infectious diseases.

Throughout her pregnancy and for the first year of her baby's life, a woman is entitled to free prescriptions and dental care.

A comprehensive programme of health surveillance is provided for pre-school children in clinics run by the community health trusts and increasingly by GPs. Information on preventive services are given and in some clinics, welfare foods are distributed.

The school health service offers healthcare and advice for schoolchildren, including medical and dental inspection and treatment where necessary.

Child guidance and child psychiatric services provide help and advice to families and children with psychological or emotional problems.

In recent years, special efforts have been made to improve cooperation between the community-based child health services and local authority education and social services for children. This is particularly important in the prevention of child abuse and for the health and welfare of children in care.

Moreover, Government recently improved Paediatric Intensive Care (PIC) services in England. It includes the development of a 24-hour retrieval service to ensure that critically ill children needing transfer to a PIC unit are accompanied by doctors and nurses trained in PIC.

- **Ambulance And Patient Transport Services**

NHS emergency ambulances are available free for cases of sudden illness or collapse, for accidents and for doctors' urgent calls. Rapid response services, in which paramedics use cars and motorcycles to reach emergency cases, have been introduced in a number of areas, particularly London and other major cities with areas of high traffic density. Helicopter ambulances also serve many parts of the country.

Non-emergency patient transport services are free to NHS patients considered by their doctor, dentist or midwife, to be medically unfit to travel by other means.

In many areas, the ambulance service organises volunteer drivers to provide a hospital car service for non-urgent patients. Patients on low incomes may be eligible for reimbursement of costs of travelling to hospital.

- **Blood Transfusion Services**

The UK is self-sufficient in blood and blood products. In England alone, 2.4 million donations are given each year by voluntary unpaid donors and separated into many different life-saving products for patients. Donors are normally aged 17 to 70.

Blood centres are responsible for blood collection, screening, processing and supplying hospital blood banks. They also provide wide-ranging laboratory, clinical research, teaching and advisory services and facilities. These are subject to nationally coordinated quality audit programmes.

- **Human fertilisation and embryology**

The world's first 'test-tube baby' was born in the UK in 1978, as a result of the technique of in vitro fertilisation. This opened up new horizons for helping with problems of infertility and for the science of embryology.

The social, ethical and legal implications were examined by a committee of inquiry under **Baroness Warnock** in 1984 and led eventually to the passage of the human fertilisation and Embryology Act 1990.

The Human Fertilisation and Embryology Authority (HFEA) licenses and controls centres providing certain infertility treatments, undertaking human embryo research or storing gametes or embryos. The HFEA maintains a code of practice giving guidance to licensed centre and reports annually to Parliament.

7.2.5. Health prevention

- **Communicable Diseases**

Health authorities have a key responsibility for prevention and control of outbreaks of infectious disease, liaising closely with colleagues in environmental health departments of local authorities. They are assisted by the Public Health Laboratory Service, which aims to protect the population from infection through the detection, diagnosis, surveillance, prevention and control of communicable diseases.

Similar programmes are carried out for immunisation against diphtheria, measles, mumps, rubella, poliomyelitis, tetanus, tuberculosis, whooping cough and haemophilus influenza infection. Immunisation is voluntary but parents are encouraged to protect their children. GPs who achieve targets of 60% and 90% uptake of child immunisation receive special payments.

Annual immunisation rates are now at their highest levels –the uptake of diphtheria, tetanus and polio immunisation by the age of two in the late 1990 was 96%. The incidence of such childhood diseases is at its lowest level. Since the introduction of the HIB vaccine in 1992, HIB meningitis has been almost completely eliminated in young children.

- **Health Education**

The aims of health education are:

- Provide information and advice about health directly to members of the public.
- Support other organisations and health professionals who provide health education to members of the public.
- Advise the Government on health education.

In addition, the Health Education Authority has the major executive responsibility for public education in the UK about AIDS. It also helps in the provision of training for HIV/AIDS workers and provides a national centre of information and advice in information and advice in health education.

Major campaigns carried out by the health education authorities include those focusing on coronary heart disease, cancer, smoking and alcohol misuse.

- **Environmental Health**

Environmental health provides public health protection through control of:

- physical environment;
- atmospheric pollution and noise;
- contaminated land, food and water;
- unfit housing;
- health and safety;
- communicable diseases;
- statutory nuisances.

Environmental health services are provided by local government.

- **Safety of Medicines and Health Arrangements with Other Countries.**

Only medicines that have been granted a marketing authorisation issued by the European Medicines Evaluation Agency (EMEA) or the Medicines Control Agency (MCA) may be sold or supplied to the public. Marketing authorisations are issued following scientific assessment on the basis of safety, quality and efficacy.

Moreover, the member states of the European Economic Area (EEA) have special health arrangements under which EEA nationals resident in a member state are entitled to receive emergency treatment, either free or at a reduced cost, during visits to other EEA countries. Treatment is provided, in most cases, on production of a valid form, which, in the UK, people should obtain from a post office before travelling.

Unless covered by the EEA arrangements, visitors to the UK are generally expected to pay for routine, non emergency treatment, or if the purpose of their visit is to seek specific medical treatment.

The UK also has a number of separate bilateral agreements with certain other countries, including Australia and New Zealand.

Chapter 8 : SOCIAL SERVICES

This chapter will deal with the British personal social services, educational policy, employment and criminal justice.

8.1. Personal social services in Britain

There is no clear category of 'personal social services', which cover both social work and social care, services to people which fall outside the remit of health services. In Britain, these departments have developed as a residual category of services not provided by other services. The categories include: mentally ill people, elderly people, offenders, neglected or abused children, children without support, physically sick and disabled people, people with learning disabilities… The services are provided within particular settings, including area teams of social work departments, day care, residential care, courts and juvenile courts or children panels, domiciliary care and hospitals.

After 1948, three departments were responsible for personal social services:

- health departments, responsible for public health and various aspects of social care;
- welfare departments, responsible for residential care and help to elderly and disabled people;
- children's departments, responsible for child care.

In the 1960s, they were unified into Social Work Departments in Scotland, and Social Services Departments (SSDs) in England and Wales. This gave the impetus to social work as a generic profession, though genericism is increasingly rare in practice.

Although much of the spending on social services went on residential care, the SSDs, and professional social work, were dominated by child care. The balance was shifted by the introduction of community care policies in the 1990s, following the Griffiths report of 1988.

The field of social work is a relatively minor part of the activity of personal social services overall.

8.1.1. Social work

Social work is to some extent defined by the activities of the personal social services and the client groups they deal with. What social workers do is interpreted in various ways. ‘Casework’, or ‘direct’ work, includes problem solving (as advisor, broker or advocate), psycho-social therapy, meeting the functional tasks of the agency, changing behaviour and crisis intervention.

Basic skills include assessment, interviewing and recording; others include group work, counseling, negotiation and advocacy. The role of the social worker, and the methods used, depend largely on the interpretation of the problems the worker is dealing with.

The Barclay report on social work also refers to ‘indirect’ social work, which includes supervising staff and volunteers, training, management, mediation and community development.

8.1.2. Child care policy

The Children’s Departments in 1948 were founded in part in response to a child care scandal. Under the 1948 Children Act, it became the duty of a local authority to ‘receive the child into care’ in cases of abuse or neglect. Local authorities gained powers to investigate neglect in 1952, and to take preventative action only in 1963. The problems of children who were deprived or abused have been connected closely with issues concerning young offenders.

The Children and Young Persons Act 1969 sought to remove any distinction between young offenders and children who had been abused or neglected.

The 1989 Children Act represents an important break with this philosophy, and removed the provisions which made it possible to admit a child to care for committing an offence.

The grounds on which a care order can be made are defined in England and Wales in the Children Act 1989. The basis for admission to care has to be the welfare of the child, taking into account his or her needs, wishes and family background. In order to be admitted to care, a child should be suffering or at risk of 'significant harm', which is defined as 'ill-treatment or the impairment of health or development', or should be beyond parental control.

The **Maria Colwell case**, in the 1970s, showed deficiencies in the new professional arrangements, and child care practice became increasingly defensive.

In the early 1980s, pressure for 'parental rights' increased. The 1989 Act, while rejecting this view, limited the circumstances under which children could be taken into care, and the numbers of children admitted to care has fallen substantially.

8.1.3. Community care policy

The idea of community care is ambiguous. It can refer to care in the community or by the community. Care in the community includes care that is not in an institution, care in ordinary housing and independence. Care by the community includes care through solidaristic social networks, care by community services, and care by informal cares.

Community care also refers to the management of care for people in the community. The central idea behind the development of 'care management' is the development of a package of care from a range of different sources. A package is thus designed for each person taking account of existing sources of support and making use of a range of options to meet that person's needs. In principle, this should mean that packages can be selected for each individual. However, the options are not always there, services are underdeveloped and over-subscribed.

When Social Services Departments were formed, the intention was to co-ordinate their activities as far as possible with health services. The Griffiths

report on Community Care, published in 1988, proposed a different kind of arrangement: rather than depending co-ordination and integration of services, there should be one service with clearly defined responsibility, which would commission services from other. This function, in the case of community care, would be performed by Social Services Departments. Each budget would be redirected to come under the SSD's control. In principle, the role of social services department would be the purchasing of care from a range of providers. The departments were to develop the range of provision they need by making contracts with providers for services. Care managers were to be responsible for allocating resources and setting priorities; practitioners would assess individual cases and guide the selection for each person.

Although the government announced that Griffiths would be implemented, the reform of community care stopped short of this. Care management in practice is unlikely to be devolved close to the practitioner level; there are not multiple purchasers, but one main purchaser – the Social Services Department; and there is much more emphasis on coordination than on choice and the market. The systems which have been put in place seem at first blush to have more in common with the planning of the 70s than with market ideology and in practice emphasis on coordinated activity with other services has increased rather than diminished. Current indications are that the services have become disorganised and demoralised .

8.1.4. Social security

The social security system is designed to secure a basic standard of living for people in financial need by providing income during periods of inability to earn (including periods of unemployment), help for families and assistance with costs arising from disablement. As the largest single area of government spending, social security amounts to about 30% of all public expenditure, compared with 13.5% in 1949-1950, the first full year after the introduction of

the welfare state. Total spending on benefits is expected to increase around a hundred million pounds these days.

There are many reasons for this growth in expenditure, not least the increasing number and range of benefits, as social security has expanded to cover both a wider range of contingencies and the changing shape and expectations of society.

In 1948, two-thirds of claimants drawing national assistance – as income support was then called – were over retirement age. Now over two thirds are below retirement age.

8.2. Britain's education policy

Free elementary education was introduced in England in 1870; secondary schools were fee-paying until 1944. 80% of children left after elementary education, which after 1918 finished at 14. The 1944 Education Act introduced free secondary education.

The dominant principle was the pursuit of equality. The system was based on a 'tripartite' structure, distinguishing grammar, technical and secondary modern. In practice, there were few technical schools, which meant the system was more bipartite than tripartite.

Non-selective or comprehensive schools were introduced gradually, but comprehensive education became government policy in the 1960s. The arguments for and against comprehensive education have been confused with other arguments about educational methods and the purposes of education.

The main arguments for comprehensives are the fact that they reduce the likelihood of discrimination or disadvantage on the basis of class, and that they improve the prospects of children of middling ability. The main argument against is that the selective system may be more consistent with the idea of equality of opportunity. Working class children who went to grammar schools did better than those who go now to comprehensive schools.

8.2.1. Educational standards

A series of conservative critiques of the education system in the 1970s argued that: the abandonment of selection had been destructive; discipline in schools had been eroded; and new teaching methods had failed.

By contrast, the schools inspectorate made a very different set of criticisms of schooling:

- comprehensives had imitated grammar schools instead of developing their own kind of curriculum;
- exams dominated the curriculum unreasonably;
- virtually, all schools let down the less able pupils.

Most schools have no problem of discipline (though the most recent OFSTED report comments on some deterioration in standards in secondary schools). The most common problem, indentified in a fifth of schools, is truancy which is condoned by parents.

The conservative government in the 1980s and 1990s introduced national assessments, and for the first time a national curriculum, shifting the locus of control from the school to the government.

The Office for standards in Education (OFSTED) plays an important role in British Education. It's officially the Office of Her Majesty's Chief Inspector of Schools in England and was set up on 1st September 1992. It is a non-ministerial government department, independent from the Department for Education & Skills.

OFSTED's remit is to improve standards of achievement and quality of education through regular independent inspection, public reporting and informed independent advice. OFSTED's principal task is the management of the system of school inspection defined originally by the Education (Schools) Act 1992. This provides for the regular inspection of all 24,000 schools in England which are wholly or mainly state-funded.

OFSTED's role has been expanded over successive years. In addition to school inspections it undertakes: reviews of local education authorities, inspects

initial teacher training courses, the private, voluntary and independent nursery sector, independent schools (including independent special schools) and service children's education and report on LEA-funded youth services. It also reports on the impact of government initiatives such as education action zones and excellence in cities.

In 2001, OFSTED has taken responsibility for inspecting all 16-19 education and training in sixth form and further education colleges. Through its area-wide inspection reports, it reviews the overall planning of education and training provision for post-16 learners throughout England.

From September 2001, OFSTED is responsible for the regulation and inspection of all early years' child care and education.

OFSTED's publications programme includes frameworks and guidance manuals to help those involved in the inspection process at all levels. It also publishes reports and surveys on many aspects of teaching and school management which highlight good practice and provide advice to government.

In addition, the dominant models in the UK have been humanism for the elite, and vocationalism for others. Humanism is moral and individualistic and Vocationalism is linked to the needs of the economy and the application of education to practical issues. Education is differentiated for different groups of people.

8.2.2. Education and social policy

Education is principally identified with schooling, though in theory it extends far beyond this, being concerned with intellectual and social development. The main emphasis within this is on children, though there is clearly scope for education all and lifelong learning.

Education has been particularly significant as an instrument of social policy, in the sense not only of policies for welfare but also as policies intended to deal with the structure of society. The aims of education include:

- liberal education: the development of each individual intellectually and socially to that person's fullest potential;
- socialisation: education is a method of transmission of social norms and values. This is also seen as a form of social control;
- education as handmaiden: the sometimes education system serves the industrial process and the economy by producing a trained workforce, and by providing child minding services;
- social change (or 'social engineering'). The education system has been seen as a means of bringing about social change.

Finch refers to the use of education as a vehicle for other types of social policy. Education provides a convenient basis for policy for children because of its universal coverage, the acceptance of responsibility for children's welfare, and because it has been easy to justify welfare measures in educational terms.

8.3. Employment services

The main response to unemployment is through economic policy, which addresses the issues by considering the workings of the economy as a whole. General measures to manage the economy have to be distinguished from 'targeted' employment measures, like employment subsidies and wage supplements, intended specifically to affect the labour market. Targeted measures are liable to be inefficient, because they help people who may not have stayed unemployed anyway, or they displace problems to other groups.

Some 29 million people were classed as economically active in the UK in June-August 1998, of whom 27.2 million were in employment: 15 million men and 12.1 million women. Employment is growing following a decline during the recession of the early 1990s, and the number in employment rose by 307,000 (1.1%) in the year to June-August 1998.

Employment services are mainly focused on the unemployed person: they offer, for example, improved information, retraining of work experience, which improves a person's comparative position in the labour market but does not of

itself create jobs. Some are based in a view of unemployment as idleness: workfare, in the US, is designed to penalise benefit claimants for not working on the assumption the claimants have a choice. There are two main approaches in UK: Activation (an idea from Denmark) seeks to promote active participation in the labour market through motivation and the development of skills. Insertion and social inclusion (from France) is based on a contract between the individual and society. The contract of insertion made between individuals and the local Commission of Insertion is matched with a responsibility on the Commission to develop opportunities.

8.4. Criminal justice

Criminal justice and penal policy sit uncomfortably with much of the other material on social services, because they are not necessarily intended to promote welfare. Historically, however, the movement for penal reform was often inseparable from other developments in welfare provision particularly those focused on the poorest. The first probation officers were appointed as missionaries, to encourage moral improvement in the criminal classes.

Punishment is generally justified in terms of retribution – returning like for like – public disapproval – reacting to unacceptable behaviour – correction – punishment is educative, guiding people to the correct path, containment – restraining offenders from further offences -, deterrence – preventing further actions, either from the offender or by others -, rehabilitation – reforming and reintegrating the offender.

The aims are mixed, and punishment often co-exists with measures to further the welfare of offenders.

There are significant differences in the system of criminal justice in England and Wales, Scotland and Northern Ireland. Scotland has its own legal system.

Most offenders in the UK are dealt with by non-custodial sentences. Custodial sentences for indictable offences by adults account for less than one

sentence in five, while fines cover more than a third of all offences. About a fifth is given intermediate sentences like probation or community service. The Probation Service (in England and Wales) administers supervision in the community, social work in prison and after care: their duty is to ’advise, assist and befriend ‘offenders.

The welfare approach has been most prominent in the treatment of young offenders. From 1963 until 1989 it was policy to treat young offenders as needing care, but since 1989 there has been a renewed emphasis on penal policy. The age of criminal responsibility is not uniform throughout the UK; in England and Wales it is 10 (though until 14 the prosecution has to prove responsibility). Custodial options for young people include detention centres (14-21), attendance centres (10-21) and youth custody (15+). A range of non-custodial activities are undertaken by Social Service Departments, intended partly to rehabilitate young offenders, and partly as ‘diversion’, intended to postpone the point at which young offenders incur custodial sentences.

CONCLUSION

In the aim of achieving this research work, we have been led to dig in history, assemble and analyse facts and data and to draw conclusions as to see whether Britain's Welfare state is a reality or a simple myth.

In this perspective, we have discussed the historical background of Britain, analysing the socio-economic situation which prevailed before the birth of the welfare state philosophy. We have seen that these historical facts are driven by the wind of the Industrial revolution which blew over most European and American nations in the 19th century, with its corollaries of consequences which paradoxically unveiled the slow emergence of poverty in the population, despite the economic development brought about by this revolutionary trend.

Addressing the other major social features which developed in the Britain society, we have discussed the great issue of health which is organised around the concept of the National Health Service with problems such as social exclusion, inequalities, deprivation, lack of access to health services, etc. an already underfunded NHS that is allegedly collapsing as it faces the twin pressures of an ageing population is indeed putting intolerable pressure on the pension system, and increasing the need for social care. The housing stock is crumbling with the implementation of the so called Urban Policy 1931, which creates homelessness and deprivation, rivalries and tensions among urban and local Housing Authorities, and between house and land owners and private tenants.

The other social issues discussed throughout the first part are unemployment, educational disadvantages with demoralised teachers and falling standards in schools, social stratification and injustice. On all these issues, the situation is the same: growing poverty, inequality and sufferings for the population. The income of the poorest 10 per cent of the population has been falling not only relatively but absolutely. These difficulties lead the government to take the bull by the horns and make their best to ensure an equal and even enjoyment of welfare for all the citizens.

So, in the second part, we discuss the tough actions taken by the government to solve all these problems and try to change the adverse social trend which develops among the population. In effect, the government has succeeded in its efforts to develop new good values in the society and the implementation of a social policy by focusing on the wellbeing of the community. They develop and reinforce solidarity, social right, justice, freedom, democracy and a new conception of the state. These tough actions yied some substantial improvements in the social problems raised so far. They put in place challenging policies for the benefit of the individuals, families and the community as a whole, and particularly for the elderly people and children on issues of equality, work, class confrontation, social stratification, gender, race, immigration, naturalisation, etc. All these resulted in a better access to education, employment, health care and justice for each British citizen.

These are the great advances achieved by the British Government in its tremendous efforts to solve the social difficulties British citizens were living in and to improve welfare in the kingdom.

We are now in a position to assert, in the face of the development made so far towards Britain, that it is neither a myth nor a mere reality. It is something in the middle. A total reality, indeed, is understood as a situation where each aspect of the social life would be rosy and shiny for all the community, but it is an ideal situation that it's not possible to attain in any country. Let's simply hope that the successive British governments will keep on their efforts for ensuring an ever-improved welfare for their citizens whatever their social position, sex, age.

Meanwhile, comparing Britain with our own country, Benin and despite the media coverage of our government's actions and achievements, we sadly observe that many things still remain to be done, after nearly twenty-five years of 'democracy, and good governance' as exercised by the politicians of the 'new age', to ensure even a minimum welfare for the population, the vast majority of whom (about 75%) live under the poverty line (less than 1 US dollar per day for

their subsistence); moreover, unemployment is at its peak, inflation is on the pressure for a constant rise, inadequacy of university curricula to modern job market requirements (contrasting with student attendance which is hindered by problems of accommodation, transportation, feeding), public health has pollution in urban centres are to be improved; in addition, environment and sewage disposal, public security, to mention only these, constitute as much hindering for a welfare state in Benin. But we can also notice the Benin government's efforts concerning some aspects such as health (free heath care for children under five years) and education (primary school is free). Thus, in spite of some weaknesses noticed in Britain's welfare, the British are still in advance compared to the present situation of welfare in Benin.

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