Meeting Needs In The Community

A Discussion Paper On Social Services

Judith Davey
Máire Dwyer

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Planning Paper No. 19
April 1984

ISSN 0111-0470
ISBN 0-908601-31-X

New Zealand Planning Council P.O. Box 5066 Wellington

The views and opinions expressed in this report are those of the authors and do not necessarily reflect those of the Planning Council.

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ACKNOWLEDGEMENTS

We would like to give special thanks to the members of the project's support group for their on-going assistance:

Marion Bruce, Federation of Voluntary Welfare Organisations
Liz Chamberlain, Tiromoana Social Work Training Centre
Anne de Lacey, Management Services and Research Unit, Department of Health
Sue Driver, Community Services Officer, Wellington City Council
Alison Gray, Sociology Department, Victoria University of Wellington
Joan Mattingley, Community Worker, Johnsonville
Owen O'Connor, Community Adviser, Lower Hutt City Council
Mary-Jane Rivers, Town & Country Planning Division, Ministry of Works and Development

Many other individuals have been consulted and have made valuable contributions, including our colleagues at the Planning Council. We would like to mention:

Raoul Ketko, Anne Frizelle, Lester Mundell, Ann Corcoran, Charlie Moore, Diane Hawkins, Department of Social Welfare
Tom Whittaker, Department of Maori Affairs
Bill Buxton, Pat Stewart, Department of Internal Affairs
Eddie Clark, Department of Education
Penny Eames, Workers' Educational Association
Trish Hall, Department of Social Work, Victoria University of Wellington
Jennie Darby, Brent Wheeler, Palmerston North City Council
John Raeburn, School of Medicine, University of Auckland
Peggy Koopman-Boyden and Alf Kirk, members of the New Zealand Planning Council
Jan Dowland, Management Services Research Unit, Department of Health

In our study of service delivery in Johnsonville, an important background to this report, we were assisted by a wide range of workers, paid and unpaid, involved in social service delivery, in the informal, voluntary and local authority sectors, and also by local residents.

CHAIRMAN'S INTRODUCTION

Over recent years, many individuals and organisations, the Planning Council among them, have called for a new approach to social service delivery which would mean less reliance on institutions and central government provision, and the promotion of 'community-based' alternatives. This proposed approach envisaged a greater role in service provision being played by the family, voluntary societies, local bodies and neighbourhood groups, trade unions and employers. Broadly it sought to express the ideal of a welfare society replacing the welfare state. Internationally, the OECD was prominent in advocating such a shift.

Should we now ask how realistic this proposition is, and how firmly based are the assumptions upon which it rests? A recent Planning Council publication, Issues in Equity (NZPC Planning Paper No. 17, 1983), was not reassuring on the extent of altruism in New Zealand society; it showed many people felt they were not receiving fair treatment, and that a high degree of cynicism was evident. The assumptions upon which the 'community-based' concept rests have also been challenged by voluntary organisations and community workers, both in New Zealand and overseas.

The Planning Council included a study of social service delivery in its 1983-84 work programme with the aim of testing some of the assumptions which have been made about the advantages and disadvantages of different systems of service delivery. It soon became apparent that this was an extremely complex and difficult area to tackle and problems arose with definitions and methodology. What is community? How should 'community-based' services be defined? Ideological differences, for instance over the meaning of community, development, power-sharing, participation and equity, are crucial to the assessment of effectiveness of services and accountability.

In order to promote debate on these and related issues, the Planning Council has chosen to publish this report as an authored discussion paper. Both the Council and the authors would welcome comment on it, and will be pursuing active follow-up in the form of meetings and discussions. It should be recognised, however, that the paper is limited in its scope and objectives. It does not attempt to be prescriptive or to make precise recommendations in the area of social planning - in fact it concludes that all sectors have a role to play in meeting needs and that central government cannot be reduced to a residual role in service delivery.

Reactions to this report, and other work presently underway in the secretariat, should assist the Council itself to reach conclusions later this year on issues raised in this paper and on the general themes of decentralisation and devolution.

I.G. Douglas
Chairman

Section 1

INTRODUCTION

1.1 Background

In its publications The Welfare State (1979) and Directions (1981), the Planning Council favoured greater flexibility, more 'community participation', better coordination, and a preventive approach in the delivery of social services. Such a 'community-based' approach paralleled the Council's support for more devolution of governmental responsibility and decentralisation of services. It also anticipated that an increase in self-help and community involvement in service delivery would lessen the demand for centralised, bureaucratic and institutional forms of service, and thus allow a reduction in the growth of the welfare state.

The Council has not been alone in its stance. The New Zealand Council of Social Service also supported a 'sharing' of social responsibility, advocating the promotion of community self-sufficiency with greater involvement of local bodies, voluntary organisations and community groups.[1] Overseas, the OECD conference on social policies in the 1980s echoed concerns about the monolithic nature and growth rate of social service systems and advocated moves towards a 'welfare society'.[2]

Dissatisfaction with the welfare state runs across the political spectrum. It is either seen as failing to meet basic needs and to achieve equity, or else it is accused of making inroads into private life and promoting the growth of bureaucracy and rising expenditure.

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1. Sharing Social Responsibility, New Zealand Council of Social Service, February 1978
2. The Welfare State in Crisis, OECD, 1981

However, calls for community-based services and a welfare society have also been criticised. Economic pressures, such as unemployment, which constrain central government income, create pressures in society which in turn cause a burgeoning of social service needs. Some suggest the thrust for community-based services is motivated by a desire to reduce government responsibility for providing care. Public participation has been seen as a management tool rather than an empowering process. This view sees the outcome of such policies as disparities in service quality and increasing inequality.[3]

The growing debate over the future shape of social policy and the welfare state makes it timely to look more closely at the assumptions that have been made about the community-based approach to service delivery. The validity of claims being made for this approach, in terms of effectiveness, efficiency, social benefit, public participation, and scope for the prevention of social ills should also be examined.

This study arises from the Planning Council's wish to look again at the assumptions made in its earlier publications. It aims to promote public debate by exploring the issues involved in meeting needs in the community and setting them before those in government departments, local authorities and ad hoc bodies, voluntary organisations and community groups, who are active in social service delivery and policy-making. The paper is not an attempt to define or measure need in the community, nor to evaluate particular social services or different delivery systems in any rigorous way.

The study was carried out in the Planning Council secretariat during 1983. As well as deriving material from published sources and from discussions with people active in social and

3. Such concerns were voiced in Davey, J.A. and Koopman-Boyden, P., Issues in Equity, NZPC, 1983

and community services,[4] the project incorporated a case study of the Wellington suburb of Johnsonville.[5]

1.2 Context and Scope

What is meant by a community-based approach to service delivery, and how does it relate to the meeting of needs?

Many statements made concerning community involvement in service delivery emphasise the shifting away of service delivery from centralised, institutionalised and uniform systems, towards less formal, more flexible and participatory services in the community. Alternatively, emphasis is placed on strengthening those services and developments within communities which aim to improve the quality of life, strengthen self-reliance and informal networks, and prevent crises and the need for treatment. These approaches are complementary and interactive. There are limits to both the decentralisation of institutional and specialised services and the ability of services within communities to meet needs. Most often both are needed - for example an accident victim requiring intensive care in hospital will also need support at home during recuperation.

The interrelationships in the system are complex. Our needs for housing, education, social support and so on are met in a variety of ways - through exchange in the market place, the informal care networks of family and friends, and by the activities of those groups more commonly identified with social service delivery - voluntary service organisations, local and central government. The roles of these groups in meeting needs are closely interrelated. A decline in economic activity limits financial resources for government-funded social services and transfer payments (welfare benefits or other forms of financial support). For central

4. See Acknowledgements

5. Gray, A., The Johnsonville Case Study, unpublished working paper, NZPC, September 1983

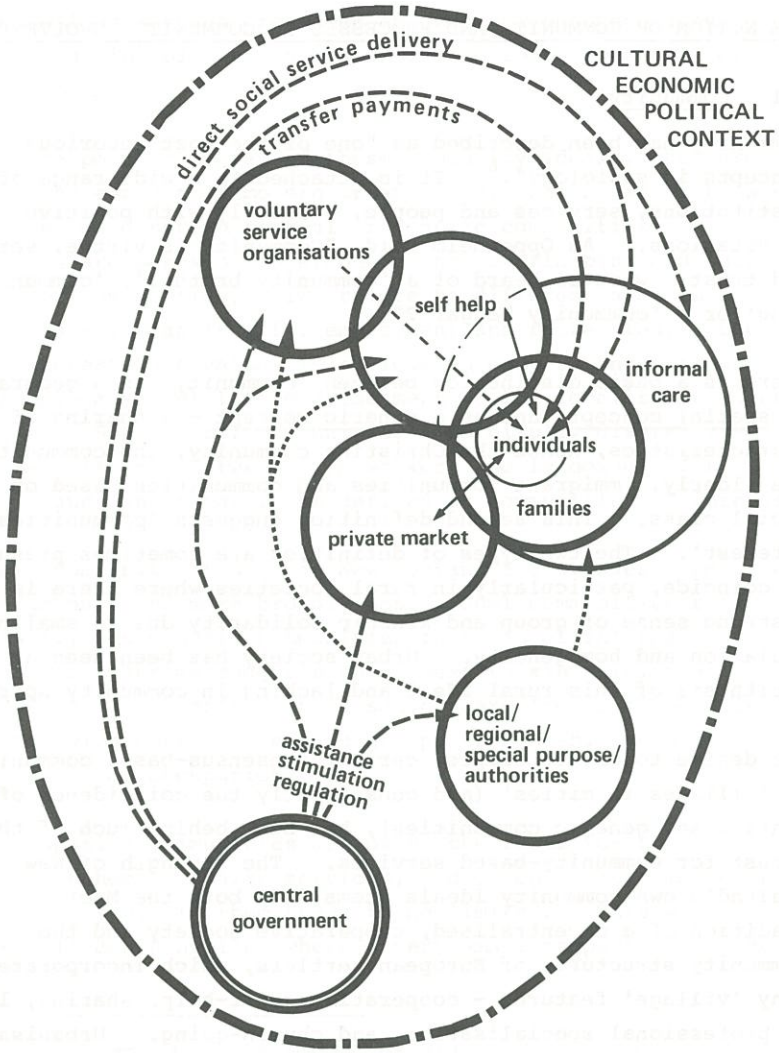
government there are trade-offs between expenditure on social services, stimulation of other deliverers of services, and transfer payments. The market's ability to meet social service needs depends on the consumer's ability and willingness to pay. Informal care will be affected by employment possibilities, income levels and the policies and programmes of service deliverers.

The relationships of these groups in meeting needs can be seen in terms of resource flows (see figure, p.5).

Over time, community initiatives often develop into specialised, nationally-based services. Several organisations, including central government and churches, have an input into both formal and bureaucratic services and those operating informally in specific communities. For example, the Department of Social Welfare is responsible for transfer payments and institutional care of children, but also contributes to voluntary organisations and community groups involved in preventive care.

The first section of this paper discusses the various interpretations given to concepts and processes central to the debate on community services. They are community, community development, public participation, and prevention.

Approaches to service provision in the community take up the main part of the report, with each sector, from informal family care to central government initiatives, examined in some detail. The final section sets out issues arising from the discussion and conclusions reached.



Flows of social services and care

Section 2

THE NOTION OF COMMUNITY AND PROCESSES OF COMMUNITY INVOLVEMENT

2.1 Community

Community has been described as "one of the most notorious concepts in sociology".[6] It is attached to a wide range of institutions, services and people, generally with positive connotations. As Oppenheim said, "Community is virtue, service and trust; whoever heard of a 'community brothel', 'community gang' or a 'community beggar'?"[7]

There is a basic distinction between 'community' as a geographical or spatial concept, and as a generic concept - a sharing of common characteristics, hence the Christian community, the community of the elderly, immigrant communities and communities based on social class. This second definition suggests 'communities of interest'. The two types of definition are sometimes presumed to coincide, particularly in rural societies where there is often a strong sense of group and kinship solidarity due to smallness, isolation and homogeneity. Urban society has been seen as the antithesis of this rural ideal and lacking in community spirit.

The desire to create simple, caring, consensus-based communities or 'villages in cities' (and consequently the coincidence of spatial and generic communities), has been behind much of the thrust for community-based services. The strength of New Zealand's own community ideals stems from both the Maori tradition of a decentralised, cooperative society and the community structures of European settlers, which incorporated many 'village' features - cooperation, self-help, sharing, lack of professional specialisation, and church-going. Urbanisation

6. In "Definitions of Community: Areas of Agreement", Rural Sociology, 20, 1955, G.A. Hillary Jr was able to list 94 definitions of the word 'community'.

7. Oppenheim, R.S., "Social Problems and the Community", Auckland at Full Stretch, ed. Bush, M.G., and Scott, C., Auckland, 1977

and rapid social change have led to a loss in the value of community in these senses. The concurrent growth of centralised and specialised service provision and control has been seen to have resulted in reliance on government to solve more and more social problems.[8]

Despite the popular appeal of these community ideals, they are naive in the context of modern urban society which cannot be seen as a series of discrete spatial or generic communities. Individuals are parts of interconnecting, overlapping and changing networks or communities, which relate to different aspects of their lives - in family life, employment and recreation. Lack of shared interests and values is obvious in many urban settings where people may feel little attachment to the locality in which they live. Small rural communities also display diversity - the social distance between farm workers and landowners for example - and cannot easily be defined as communities of interest.

Moreover, community studies in New Zealand and overseas indicate that neighbours and more broadly based local communities rank below family and generic communities in terms of informal care and support. Abrams suggests that, next to kin care, the strongest bases for self-help in society are 'moral communities' associated with churches, ethnic groups, friendship networks and certain kinds of occupation.[9]

Although spatial communities are often the focus for social services - schools, health services, and so on - the commitment of individuals within them tends to be limited. This was reflected in Johnsonville, where a very small proportion of the

8. Dyce, T., "Community in New Zealand" in Dyce, T., and Willcox, W., eds, Opportunities for Change, Vol.1, Community Forum, 1979

9. Abrams, P., "Community Care: Some Research Problems and Priorities", Policy and Politics, Vol.6, 1977

population participated in local political activity.[10] Moreover, there were few local initiatives in service delivery. Those in existence generally emerged from specific interests, such as church membership or responsibility for care of pre-school children. The design of the local swimming pool, which was open to community decision, elicited a lot of conflict among local residents. This has implications for policies designed to develop self-reliance and facilitate autonomy in service delivery at this level.

2.2 Community Development

Community development is generally defined as the process by which communities decide on their own needs and priorities, acquire knowledge, and develop and gain access to resources and support systems to meet those needs. Although commonly identified with spatial communities, the concept of community development is also relevant to generic communities - the interest in self-determination and preservation of tradition within Maori communities is an example. The process implies the strengthening of existing communities from within, in contrast to the organisation of communities by outside forces. Change within communities demonstrates the on-going nature of community development. It is often spontaneous, especially in situations of crisis or threat - the action taken by Wellington's Aro Valley residents in response to an urban renewal plan is one example. Community development has also been assisted in recent years through the appointment of community workers and funding of activities or facilities.

There are several different aspects to community work. Simply stated, neighbourhood or locality development refers to the process whereby members of a physical community are assisted in defining

10. In Pearson's study of Johnsonville, only 4 percent of his sample population belonged to service clubs or progressive associations and a mere 2.5 percent participated in other political activities. Pearson, D., Johnsonville: Continuity and Change in a New Zealand Township, George Allen & Unwin, 1980.

their own needs and finding appropriate solutions; social planning is an analytical approach toward the identification and solution of the specific problems of an individual community; social action involves assistance to disadvantaged groups in the conflict over the distribution of scarce resources.[11]

These models of community work practice are not exclusive and community workers may adopt them all in their work. At different times community workers may operate as facilitators of harmony and consensus, professional experts in search of rational solutions, or advocates for the redistribution of power and resources.

The outcome of community work will vary according to the emphasis given. Facilitators may find that existing power biases are reinforced by 'community' choice. In other words, it is still an elite group which retains power, but at a different level and on a different basis. An emphasis on 'objective' and expert choice limits the role of lay people in decision-making. Assistance focused on empowering disadvantaged groups, rather than merely planning for their needs, challenges the status quo. The wide variety of tasks expected of, and undertaken by, community workers in New Zealand is reinforced by the range of organisations involved in community work in central and local government, churches and other voluntary groups. In all cases community workers have the potential to be important links between lay people and institutions. Most paid workers are employed by local authorities where they often take on the role of coordinating local groups, providing information on funding, advice, support or the use of community facilities, such as community houses. Whilst workers in the voluntary sector generally have more flexibility in their work, they often lack secure financial backing.

11. These models were identified by Rothman and the goals, assumptions, characteristics and strategies are outlined in Appendix I. For a critique from a New Zealand perspective see Hall, T., and Shirley, I., "Development as Methodology and Locality Development, Social Planning and Social Action" in Development Tracks, ed. Shirley, I., Dunmore Press, 1982.

Community workers often see themselves as catalysts of social action and admit to tension concerning their mode of practice resulting from differing expectations by the employing authority and the varying sectors of a locally defined community. Consequently it is difficult to generalise on the extent to which community work leads to a truly participatory process of development and local or group definition of need.[12]

2.3 Public Participation

Two aspects of participation, participation in decision-making and participation in carrying out tasks, have been considered important as part of community involvement in social services. They do not necessarily occur simultaneously.

Participation in decision-making

Activities which have been described as participation in decision-making range from publicity and improving information systems through to consumer control.[13] The greater the amount of participation, the more complex and time-consuming the process of decision-making tends to be. Presenting a decision in an attractive way is far easier than consciously promoting participation, which can extend beyond dissemination of information, surveys and public meetings to the use of natural meeting places (shopping centres, marae and factories) and advocacy for disadvantaged groups, to ensure a representative decision. Ultimately it implies the on-going service of and accountability to the public by professionals and politicians.

A participatory process is more manageable and meaningful in smaller catchment areas. In New Zealand, given the strength of

12. One example of community work intervention leading to the establishment of a community centre which did not necessarily reflect residents' needs is documented in O'Connor, J.O., Community Work Intervention Strategy in Newtown, MPP Thesis, Victoria University of Wellington, 1978.

13. These have been classified by Arnstein as degrees of non-participation, tokenism and citizen power. See Arnstein, S., "Ladder of Citizen Participation", Journal of the Town Planning Institute, Vol.57, No. 4, April 1971.

central government, it has particular relevance to the concept of devolution. This may result from central government conferring some degree of autonomy on its district offices, the strengthening of local government at the expense of central government, or the giving over of responsibilities to the public and non-governmental organisations. Supporters of devolution range from those who merely wish to arrest the centralising tendency of government, to advocates of a complete re-structuring of society.

As well as concerns for the process and point of decision-making, arguments for greater participation are relevant to the individual consumers of services. The arguments in favour of greater personal involvement in decision-making include reactions against both the power of professional groups and public dependency on statutory and other service agencies.

Many professionals work on a model of applying expert knowledge to the analysis and treatment of an individual's problem and see themselves as able to make the best decision. This approach is in opposition to self-help, which emphasises an enabling process - people acquiring access to information so they can make their own decisions.

The self-help philosophy has impacts throughout the social services - in health, welfare and education, and has been recognised as valid by many professionals. It is closely connected with support for public participation and community work, sharing the belief not only in the ability, but also in the right of individuals to make decisions affecting their own lives. In the extreme it questions many of the statutory controls and, in certain areas, rejects professional expertise and the notion that people have problems. It sees social need as arising from societal dysfunction and suggests resolution of these problems will come about only through work within society. Welfare is seen as encouraging dependence, taking power away from individuals (and,

in this sense, anti-democratic), and tackling symptoms, not causes of problems. Self-help is a reaction against dependency and offers a greater role for individuals, families and community groups in developing services and care.

Participation in service delivery and care

The desirability of more public participation in social services has included support for more family-based care (of the handicapped, elderly) and a greater contribution from voluntary workers and voluntary agencies in service provision. This can be construed as an extension of community and individual development - the encouragement to families or self-defined groups to meet their own goals in their own ways - or as the use of families, volunteers and voluntary agencies in meeting the goals set by the wider community. It implies participation in service delivery or care, with or without, direct participation in decision-making. Such participation also hints at self-reliance and responsibility for prevention. There is, however, a difference between preventive campaigns conducted by central agencies, such as defensive driving and anti-smoking, and those arising from community concerns which stress individual definition of need and self-help.

The New Zealand experience

Within New Zealand participation has been valued for itself, as an active democratic process, and also as a means to improved decision-making. There has been considerable discussion on the importance of participation in decision-making, extending from open government to client participation in services.

In the political arena, particular stress on participation has occurred in planning procedures at local and regional levels. Objectives tend to be vague. While in recent years the planning division of the Auckland Regional Authority adhered to a philosophy of public participation, the actual responses of officers ranged from an emphasis on advertising and communication,

to intervention in an advocate role. Though flexibility and variety of response is appropriate, the lack of common philosophy exemplifies much of the confusion and mixed motives surrounding public participation.[14]

Traditionally New Zealand has had public participation in quasi-public bodies, such as hospital and education boards and school committees. Such organisations have always been considered a way for public opinion to be voiced and integrated into action. Supporters of greater public participation have often looked towards these bodies and other local or ad hoc authorities as one of the means by which a devolutionary process can occur.

However, defensive reactions by certain professional groups and centrally-determined policy limit participation in these organisations. Hospital boards frequently complain of their powers being limited by Department of Health rules. School committees have no input into curricula. The recent Education Board reaction against parents who attempted to set up alternative school committees and define needs as they saw fit, suggests that traditional school committees and other such forms of participation do not necessarily contribute to the development of local communities.

While many opportunities to participate in both decision-making and service exist, the question of who participates and how, reoccurs throughout this paper. There are no easy ways of communicating with statutory organisations. The accepted processes of petitions and deputations are not widely used, are time-consuming, and appeal most to educated, well resourced groups. Similarly a very small and unrepresentative sector of the population stands for public office and, apart from some increase in female involvement in local bodies and school committees, there is no indication that this is changing. Participation in unpaid

14. Ryan, K. The Auckland Regional Authority: Public Participation and Planning, Auckland Regional Authority, May 1979

service delivery and care, on the other hand, is predominantly undertaken by women. Thus support for greater participation in decision-making and service work has implications for equity and social justice.

2.4 Prevention

There are several aspects to preventive work in the social area. Some involve increased social control - legislation backed by penalties prohibits assault, theft, and certain kinds of self-medication. Another aspect is the maintenance of minimum standards of living through transfer payments and regulations (health, housing, employment and so on). Preventive services can be universal (innoculation, water fluoridation), or selectively targeted to those 'at risk' or most disadvantaged. In a much broader sense, prevention, particularly of crisis situations, depends on individual self-reliance, confidence, knowledge and access to resources.

Much of the preventive work within social service organisations is educative, particularly in health services, or closely linked with moves to reduce institutional care or ensure rehabilitation. New developments in preventive social services have generally focused on reducing the need for institutional care or treatment. This is reflected in many of the community health facilities set up with 'beer and baccy' funding, and the preventive care programmes of the Department of Social Welfare which focus on work with 'at risk' children and the disabled.

Prevention can also entail an emphasis on client participation representing a belief in the greater effectiveness of policies that reflect 'grassroots' needs or the importance of positive programme development rather than control. The broader the view of preventive work, the closer the links with concepts of community development.

While the case for a broader view of prevention is appealing, the funding of work in this area has proved difficult. In the past, developmental or preventive work based in the community often took the form of new programmes and were funded as such. Currently there is a greater emphasis on compensatory savings and any expansion of preventive work must generally demonstrate a reduction in the need for institutional or other services. A wide range of developmental or educative programmes, support and self-help groups may achieve this aim indirectly, but their effectiveness cannot be easily measured in these terms. Moreover, the encouragement of individual resourcefulness and self-reliance may lead to greater demands for state services or assistance. A woman who gains the confidence to leave a violent marriage may then require support for herself and her children. Self-help groups often aim to ensure people get access to the services to which they are entitled.

Section 3

COMMUNITY-BASED SERVICES WITHIN THE SECTORS

3.1 The Informal Sector

A wide spectrum of needs are met, by kinship and other networks, on an informal basis. These include familial care or family-based voluntary care, such as fostering, and spontaneous initiatives for care and support that occur on an informal and generally reciprocal or self-help basis.

Encouragement for community care of dependants outside an institutional setting is increasing the demands on familial care and that undertaken voluntarily by groups or individuals. Disappointment in the performance of institutions in 'curing' problems - indeed a concern, particularly in custodial settings, that for many they create as many problems as they solve - along with escalating institutional costs of providing such care, have led to greater pushes to maintain the disabled, sick, elderly, 'deviants' and state wards in the community where possible. Strengthening these pragmatic concerns is the view that community care is more humane and better for the client. Community care cannot be seen as distinct from institutional care or specialist treatment. The ill or disabled often receive regular treatment in institutions while living with their families. Similarly, many institutions, such as rest homes run by voluntary agencies, may involve a large component of care by families or volunteers. In England, the authors of the Barclay Report saw outside support of caring networks, particularly within the family, as reducing the breakdown of such care and the consequent need for formal services.[15] Policy-makers here have also seen this approach as attractive.

15. Social Workers: Their Roles and Tasks, (The Barclay Report), London, Bedford Square Press, 1982

The growth of informal initiatives for care and support has also been encouraged. This too stems in part from disillusionment with many professional, institutional and welfare responses to needs and the growing emphasis on community development and consumer involvement. Anti-welfarism and the rejection of traditional models of professional help has resulted in the establishment of self-help groups, concerned with self-care, education and advocacy, that range across the social services. Many community workers see these kinds of initiatives as the key to the development of self-reliance and participation at the grass roots level and actively encourage them, particularly amongst disadvantaged groups - the homeless, beneficiaries, low income families and so on.

Discussion in this section focuses on the actual and potential role in meeting needs of familial and family-based voluntary care on the one hand, and informal initiatives on the other.

Familial care

As with the care of children, the physical and psychological support of the elderly or handicapped living in the community falls heavily on family members, typically women. Such care is extensive; in New Zealand only 6.2 percent of the population over 65 live in institutions. A Wellington survey found that 80 percent of severely handicapped people and 33 percent of the very severely handicapped are living in the community.[16]

There are indications that for both financial and social reasons it is becoming more difficult for families to provide ongoing care. The proportion of frail elderly people is increasing; longevity is a contributing factor. The decline in family

16. Physical Disability: Results of a Survey in the Wellington Hospital Board Area, Wellington, Department of Health, 1981, cited in Taylor, B.B. and Dodwell, P., A New Perspective on Geriatric Bed Planning Guidelines, discussion paper ANSEARCH conference, October 1983

and household size is severely reducing the ability to share the responsibility for care.[17] Despite the role of voluntary organisations in providing care and contact for the elderly, they themselves value most the assistance given by their children. Although a commitment to caring for elderly relatives is undoubtedly rewarding in many respects, it has been shown to cause stress to a high proportion of the carers when it had to be maintained for a long period. Fatigue, anxiety and other health effects were felt by two-thirds of the carers in a Christchurch sample. The sample also showed that two-thirds of the dependent elderly had daughters who dropped in for more than an hour every day, and nearly 10 percent spent as much as six hours a day with their elderly parent.[18] Family support fo the elderly and other dependants may therefore have serious negative consequences for the carers themselves and their own immediate families. The lack of reciprocity in care for the severely disabled results in the major burden being carried by families. In Pakuranga, Park noted that long-term support and high levels of short-term care are not easily supplied by informal social relations because people are reluctant to depend on friends and neighbours.[19] This confirms that friends and neighbours generally rank below family as a source of social support.

Although there has been an increase in some support services for the elderly and handicapped living at home, these are still far from adequate. The need to ration many semi-public and voluntary services or outreaches has led to services such as Meals on Wheels

17. A piece of research in Britain suggests that while the typical couple married in 1920 and still alive today has 42 living female relatives of whom 14 are not in paid work, the typical couple married in 1950 is likely, at 80 years of age, to have only 11 living female relatives of whom 3 will not be in paid employment - cited in Hadley, R., and Hatch, S., Centralised Social Services and Participatory Alternatives, George Allen & Unwin, 1981.

18. Koopman-Boyden, P., "The Family and its Elderly Members", Ageing New Zealanders, a report to the World Assembly on the Ageing, 1982

19. Park, J., Doing Well - An Ethnography of Coping, University of Auckland, Department of Anthropology, Working Paper 61, 1982

being limited to the sick and elderly who live alone without adequate familial support. Effectively this imposes an extra burden on families who actively assist their elderly members. As many of these services depend on volunteers, their growth is also predominantly dependent on the unpaid contribution of women.

Provisions to assist full-time carers are not generous - most are not eligible for the income maintenance-based domestic purposes benefit,[20] and the four weeks of alternative care provided by the Social Welfare Department to give relief is generally in an institution unless the family itself finds an alternative care giver. Transfer payments for the disabled vary according to their age, cause of disability and marital status, exacerbating the inequities in the burden of care.

The extent to which the state can and should support family care is contentious. Many people are reluctant to take money, feeling strongly that this is their duty and expected of them. Yet responsibilities for caring for family can produce inordinate financial, physical and psychological strain.

The minimal assistance given to familial care supports the widespread belief that it is cheaper than institutional care. Studies indicate that when all the costs of caring for the severely disabled, including those to the family, are taken into account the arguments are inconclusive.[21] The costs to families can be considerable as indicated by an Australian study, which found that over 50 percent of the primary carers of the elderly were forced to give up a job.[22] Moreover, in practical terms

20. Only 286 women and 58 men caring for the disabled or ill were in receipt of this benefit at 31 March 1983 - Department of Social Welfare, report for year ending 31 March 1983.

21. Dalby, B. and Ward, J., "Comparative Costs of Alternative Forms of Care for the Elderly", NZ Economic Papers, Vol.16, 1982, for example

22. Kinnear, D. and Graycar, A., "Family Care of Elderly People: Australian Perspectives", SWRC Reports and Proceedings, No. 23, 1982

we may have reached the limit of non-institutional care. Malcolm notes that concerns for effectiveness, efficiency and acceptability often mean that institutions are the most appropriate location for care.[23]

Family-based voluntary care

Examples of family-based voluntary care include foster care and the Maatua Whangai scheme.

Foster care is well established in New Zealand. Currently there is an emphasis on preventing children coming into care through the use of short-term supervision orders and the maintenance of natural family ties where possible. Fostering is not paid and assistance is limited to board rates. This reflects its closeness to family care and a reluctance to turn fostering into a business or job. Where children are fostered out to relatives, the question of the boundary of family and state responsibility appears and board rates are not automatically paid. Foster parents are not trained but they do have regular contact with a social worker. In Auckland and Christchurch, intensive back-up is currently available on a trial basis to those caring for children with special needs. There is a high turnover of foster homes for those in care and a low number of suitable applicants for foster parent positions, which seems to suggest the need for more service, and perhaps financial support.

The Maatua Whangai scheme is a new joint programme of the Departments of Maori Affairs, Social Welfare and Justice. It aims to offer a more appropriate cultural environment for foster care to Maori children coming out of institutions, set up programmes to prevent children going into welfare homes and to increase the viability of alternatives to custodial care. The Department of Maori Affairs has made some resources available to this programme in addition to the standard Social Welfare provisions.

23. Malcolm, L., "Economic Aspects of the Institutional versus Community Care Debate", NZ Health Review, Summer 1983

The concept of the Maatua Whangai programme has been warmly received within many Maori communities. Its impact on those communities is not yet clear. The programme is dependent on the willingness of groups or individuals to take on responsibilities but, as with family care, the closeness of networks may obligate people to take on more caring responsibilities than they can cope with.

The major responsibility of community care, both familial and voluntary, falls primarily on the parent remaining at home. In the case of Maatua Whangai it may also impose a disproportionate social cost on Maori communities which, while strong on care, often lack the financial resources to cope with extra familial needs. The limits additional responsibilities place on the income earning potential of a family suggest that lower incomes are a cost of caring.

The extent to which community care policies have negative impacts on families providing care needs to be addressed, as it appears the responsibility for care is distributed inequitably. What may be cheapest for the state, and in the best interests of the patient or client, may prove an insupportable burden for family members or well-intended volunteers, particularly where support systems are lacking.

Informal initiatives

Informal initiatives in care and service delivery are generally viewed favourably as healthy, spontaneous self-reliance, in the same way as new initiatives in business are applauded. Such initiatives in the social service area may have commercial, welfare or self-help objectives. Many become established organisations over time - in either the private or voluntary sector. Other initiatives may develop within agencies. This discussion focuses on informal initiatives which embody some participation or self-help - that is, groups based on mutual support either through their composition of client members

(e.g. incest survivors, schizophrenia fellowship) or those who share a common goal (rape crisis centres, playgroups, work cooperatives).

Policy-makers have shown ambivalent attitudes to the implications of self-help. On the one hand, it is praised as the growth of self-reliance, independence and mutual aid which will reduce and alleviate life's crises, placing fewer demands on social services. On the other, self-help groups are often advocates of a cause, seeking changes, questioning the reasons why they are 'disadvantaged' and are more interested in assisting their group by obtaining a greater share of available resources than cooperating in an exercise of preventive care.

Further, the growth of self-help groups can conflict with and be opposed by professional interests. In the past, playcentre and independent pre-schools were seen as a threat to kindergarten teachers. They have certainly curtailed the rate of growth of kindergartens. Women's health centres may be perceived as being in competition with more traditional health services. Their growth also raises the question of the extent to which such groups can provide adequate, appropriate and effective support for members. This can be contentious with groups such as ex-prisoners and psychiatric patients where traditional services have had a strong element of social control. In any event, respect for expertise and professional standards is not antithetical to self-help. Many self-help groups are keen to use professionals as a resource, or see their own work as complementary to established services.

Self-help schemes frequently have difficulty in meeting funding criteria, as their objectives are often determined outside the framework of welfare and service provision. Funding for pre-schools for example, requires that regular sessions of a specified length be offered and subsidies for trained staff are available only for those who have completed approved courses.

Whilst accountability for funding is essential, current rigidities probably have the effect of standardising rather than fostering community definition of needs. The tendency of community and voluntary groups to redefine their objectives in order to qualify for funds is well known.

Informal self-help initiatives are also often unsuccessful in obtaining funding because they are competing for resources with larger well-established agencies. Special funds do exist for new initiatives but such funding is short-term, and groups may find it difficult to secure alternate sources when they are no longer new or innovative. Associated with this is the tendency for small, locally-based groups that do obtain funding to develop into larger, often nationally-based, organisations over time. Most organisations will want to secure funding and some paid employees to ensure the continuance and effectiveness of their service delivery. This is difficult for them to do as small, autonomous units. Larger organisations find it easier to obtain funding but local determination and self-help can be sacrificed in the process of ensuring secure service delivery. Playcentre and the Family Planning Association are recent examples of the transition from local initiative to national federation.[24]

A more profound reason for funding difficulties relates to the kinds of goals which self-help groups set. Spending within most social service departments is geared towards uniform service provision and ameliorative services. The preventive and promotive work done by these departments is usually tied closely to their principal concern, and so they may wish to subsidise only programmes in the non-government sector which are similarly focused.

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24. Two perspectives of the implications of growth on the Family Planning Association can be found in Gibb, J., "The Family Planning Association", Opportunities for Change, Vol.2, Community Forum, 1979; and Fenwick, P., and McKenzie, M., "Feminist Health Alternatives - Safety Valves for the System", Women's Studies Association Research Papers, 1978

Thus where objectives are broadly promotive of well-being rather than directly preventive - educational, cultural and craft activities for example - funding is often difficult to obtain from social service departments.

The major exceptions are the programmes of Departments of Internal Affairs and Maori Affairs which focus more on developmental work within communities. In both cases the range of activities covered is broad, grants tend to be small and often limited to innovations. Recently the Telethon campaigns have created new sources of funding through the consequent formation of groups such as the Mental Health Foundation which are also assisting locally-based groups.

In Johnsonville, few informal initiatives were encountered outside the traditional self-funded, locally-based activities of churches and sport and recreational clubs. This may not be typical. However, in Johnsonville it did in part reflect the difficulties such initiatives have in obtaining resources and credibility within the community.

3.2 The Voluntary Sector

The voluntary sector includes non-statutory, non-profit organisations which have service, welfare or support objectives. They do not necessarily rely on voluntary labour and many of the larger, well-established agencies are staffed by paid professionals. All these organisations are accountable to their members and are managed by member representatives in a voluntary capacity. However, voluntary organisations such as Plunket and Marriage Guidance, which have continuing funding and are closely integrated with state service provision, may be more aptly labelled 'non-governmental organisations', as the influence of volunteers and ordinary members is very small.

The independent status of, and member participation within, the voluntary sector has led to it being seen as community-based. A

wide range of activities are covered by groups within the sector and it cannot be presumed that voluntary agencies fit any particular pattern of care or service delivery and that their greater role in meeting needs will result in more client participation, self-help and so on.

Many agencies, particularly the larger ones, are concerned with on-going service provision. Services may be ameliorative, preventive or promotive. Concerns may be specific to a group or aimed at a wider section of society. Provision may be supplementary or complementary to government activity (kindergarten, Rehabilitation League) or provide alternative services or other resources (women's health centres). The objectives of some groups are essentially political, others may or may not play a direct role in pressuring for change. Many service-oriented organisations operate on a welfare model of client 'treatment', others have grown out of a self-help movement and maintain a membership of consumers. Still others have been influenced by self-help techniques. Because they are non-statutory, voluntary agencies may be able to respond flexibly to needs and may provide support services such as confidential counselling, which are perhaps inappropriate for a statutory body. At the same time they lack on-going funding and accountability to the public, and their policies may be ad hoc, short-term and vulnerable to domination by strong individuals.

Community services and community development within the voluntary sector

Several developments within the voluntary sector are important in the discussion of community-based services. There has been a growth in the number of agencies, both new and established, which operate on principles of self-help, and changes in central government policies have provided more opportunities, both paid and unpaid, for voluntary agencies to become involved in service delivery. Some changes have emphasised preventive work. Local autonomy of voluntary agencies is important for participation (although the need to obtain stable and long-term funding often threatens this).

Sig. 2

Some volunteer services are very democratic in the sense of involvement and decision-making. Rape Crisis Centres and Women's Refuges are often good examples as they tend to be locally based and autonomous (federations at national level are beginning to emerge). They are mostly run on a collective, consensus principle and many of the volunteers are former victims of rape or domestic violence.

The quality of assistance through self-help is recognised more and more. Several years ago, blind people within the Royal Foundation for the Blind challenged the organisation's policies. As a result, it now works on self-help rather than welfare principles, providing employment for its members where possible. The importance of consumer representation is now acknowledged by other groups with a traditional welfare orientation - intellectually handicapped people had their first conference in 1983.

Several central government policies aim to increase the role of voluntary agencies in social service delivery (or care in the community as it is often called) by increasing their opportunities to contribute and lessen central government activity. Two examples are the community service sentence and the Department of Labour work skill development programme projects.

The community service sentence was recently introduced by the Department of Justice. Envisaged in the legislation as an alternate method of dealing with offenders who would otherwise go to prison, the sentence was designed to enable more effective rehabilitation of offenders who respond to self-motivation. The sentence has been fairly widely used (1,833 orders in the 1981/82 year), and generally involves an offender working for a voluntary organisation. While it has been successful in some areas, the lack of monetary support and adequate supervision is a factor in the reluctance of some groups to use the scheme.[25]

25. This was noted in the Johnsonville case study where local groups felt uncomfortable about 'policing' or saw their way of working as antithetical to supervision. One group that did take on an offender found the responsibility unwelcome and troublesome.

The work skills development programme relies on voluntary agencies and local authorities taking the initiative and responsibility for the training of young unemployed people. Because of the responsibilities involved it has tended to be the larger organisations which take on these schemes. There are over 100 schemes operating throughout the country, with the Salvation Army playing a particularly large role. Some are undertaken by local groups, particularly in Maori communities. Although many are working well, the criteria for these schemes are narrow and largely outside the control of the voluntary agency, let alone the clients. One scheme, operated by Plunket, trains young women as home helps. Controversy has resulted, centred on the ethics of work which reinforces traditional and low-paid occupations for women, with inadequate training and career prospects.

Other Department of Labour employment and training schemes such as the School Leavers' Training and Employment Scheme (STEPS) are also dependent on take-up by voluntary agencies. Again, there is no requirement for participation by clients or the wider community. Indirectly, however, these schemes have led to a greater awareness of, and emphasis on, the problems caused by unemployment. The schemes' relatively generous resource provisions have resulted in the extensive expansion of such services for the unemployed by certain voluntary agencies, the Salvation Army and YMCA in particular.

Some policies influencing the voluntary sector do emphasise participation or prevention. The Department of Social Welfare has several programmes for preventive care of children or 'at risk' youth. Some of these arose from the work of the Committee on Gangs in 1981. Community health funds have resulted in voluntary agencies, along with hospital boards and the Department of Health itself, setting up outreaches, small centres for care, and so on.

Indirectly, voluntary organisations have picked up assistance through Department of Labour employment and training programmes. A proliferation of short-term jobs for coordinators, researchers, and community workers has strengthened many groups temporarily. But dependence on these new employees often creates difficulties when they leave. The ultimate responsibility for paying employees salaries in many half-way houses, refuges, work training programmes, recreational and cultural activities, and the most appropriate way of making such payments, has not been resolved.

There have been some changes within the voluntary sector which can be described as participatory, preventive or community-based. However, they have occurred against a background of funding biased in favour of large, bureaucratic service organisations.

Resources for the voluntary sector

The policy of central government support for voluntary sector service provision is well established and many organisations depend on it for their survival. They also receive revenue from local government, donations and their own fund-raising, as well as being heavily reliant on voluntary labour.[26]

The inter-dependence of government and the voluntary sector is multi-faceted and has grown over time. Voluntary agencies have served to draw attention to needs which have been taken up by government, e.g. family day care, women's refuges. As well as direct subsidy and support, government can influence the voluntary sector through regulation, tax and transfer policies.

26. No nation-wide survey of voluntary organisation funding exists. However, a Palmerston North study of 109 non-statutory welfare organisations indicated that grants provided 44 percent of the income of these organisations and 56 percent of grants came from central government. It also estimated that over 5,000 hours a week were worked by volunteers for agencies (in a population of 50,000) - Research into Non-Statutory Welfare Organisations in Palmerston North, Interim report, Palmerston North Community Service Council, August 1982.

State support of voluntary organisations as the providers in key social services can change their nature. It is difficult to avoid some erosion of the freedom, adaptability and local focus of voluntary agencies when state funding is their mainstay. Most of the grants available are centrally distributed and designed for specific projects. This favours, perhaps inadvertently, the development of national bodies and the standardisation of services. In fact, the greater proportion of subsidies go to large nationally-based organisations. In the case of the Citizens Advice Bureaux, for example, a large portion of their grant is specifically for national body administration.

This bias towards funding nationally-based, established groups is particularly strong in the areas of health and social welfare, where the respective departments have policies of supporting non-governmental service provision. Douglas notes:

> *"Voluntary organisations which have always provided for specialist needs such as the Crippled Children Society and the Intellectually Handicapped Society have grown into large bureaucracies making it difficult for smaller, locally-based groups to have access to funds."* 27

A wide range of services that we have come to accept as essential, are provided by voluntary organisations, heavily subsidised by state funds. The New Zealand Society for the Intellectually Handicapped, for example, received a $10.9 million subsidy in 1981/82 - about half its budget. The Crippled Children Society, Plunket Society and the Royal Foundation for the Blind are other recipients of extensive subsidies and are dependent upon them to maintain their services. Whilst these subsidies are significant for the voluntary agencies, they are a very small proportion of departmental budgets.[28]

27. Douglas, D.J., CAB and the Volunteers, Research essay MA (Applied) Social Work, Victoria University, 1978

28. See Appendix II: Examples of central government expenditure on grants and subsidies to non-governmental agencies and services in 1982/83

The limitations of voluntary organisations

It cannot be assumed that an increased role of the voluntary sector in service provision will, on its own, lead to better, more effective, or more participatory services. Even though the voluntary sector is seen as the community looking after its own, in the same way that families are encouraged to do, the autonomy of any voluntary organisation is limited by a range of controls imposed by government - requirements for legal incorporation, financial accountability, licensing and so on - and by dependence on direct or indirect government subsidies. There are no indications that the need for state assistance is decreasing. The growing emphasis on professional care and training within this sector suggests the opposite. The voluntary sector can probably produce more for each dollar granted, however. Some consideration of the time and energy of volunteers involved in the process of fund-raising is also necessary. Agencies frequently note the limitations imposed on their work by the need to raise funds.

Furthermore, voluntary systems do not necessarily develop wherever there is need. Like churches, voluntary agencies to a large extent choose their own path and are not amenable to widespread coordination or structuring from outside. They are directed by the concerns and priorities of volunteers themselves and this may lead them to concentrate on political action, welfare or community activities depending on their lifestyle and value system. The long-term support for families caring for severely disabled or sick members is just one example of a need that is not well met by voluntary organisations. Many of the larger organisations such as Barnardos, the Society for the Intellectually Handicapped and the Federation of Kindergarten Associations provide non-profit services with paid staff, using government subsidies. Such groups tend to bring an established service to a community rather than encouraging local definition and diversity.

Finally, many aspects of welfare state activity, such as social work, are also concerned with social control, and it may be

inappropriate to enlist the endeavours of voluntary agencies or volunteers who lack accountability and statutory responsibility.

3.3 Local Government

Local government incorporates regional or united councils in the regions as well as the local territorial authorities. The Auckland Regional Authority has an active community development section and an established interest in this area. Its activities include social surveys, advocacy for community groups and social planning in the Auckland region. The newer Wellington Regional Council has also appointed a community adviser. Not having the capacity to employ their own staff, the united councils tend to restrict themselves to a coordinating and planning role in their regions and have not become directly involved in social or community services. Exceptions are in areas of major project development (Taranaki and Northland) where social impact monitoring, partially funded through National Development Levy provisions, is being carried out.

Traditionally, territorial authorities have been predominantly concerned with the physical needs of their areas and apart from recreation facilities and, in a few areas, housing, have played a limited role in social service provision. This contrasts with many other countries, such as Britain, where local authorities have social service responsibilities. More recently an interest in community development and service provision has emerged in local authorities.

Several factors, including needs arising from rapid urban growth in the 60s and 70s and the linking of funding for recreation with community development (such as the $1 per head Ministry of Recreation and Sport grant), have led to the appointment of community workers in local authorities, under a variety of titles, differing in their status and command over resources. Through their community workers, social planning and community development

programmes, local authorities have become involved in the encouragement and development of community services, the establishment and support of community facilities, such as emergency housing, child care centres and community houses, and employment promotion (particularly through the use of Department of Labour employment and training schemes).

Whilst much of the development work within communities has been supported by local authorities, such efforts are by no means evenly spread throughout the country. There are as many examples of conservatism and diffidence as there are of innovation and enthusiasm, and approaches to community development and participation in services are varied. An understanding of community development and social planning enriches the planning process and is easily integrated into it. However, it also leads local authorities towards concerns that border on welfare. There is a strong feeling that 'social services' and 'welfare' are central government responsibilities, but that somehow such responsibilities are being pushed onto local government which lacks the financial resources to cope. This feeling is unjustified in the case of community development which has never been a central government function either and is not easily stimulated and funded by a central government, based in Wellington and responsible to taxpayers on a national level. As a result of the developments described there has been a blurring of the boundary between central and local government functions.

The potential role of local authorities

If territorial authorities are to play a greater role in community-based services, several issues must be considered:

(a) boundaries -
Local authorities have definite spatial boundaries which delineate their areas of responsibility. These boundaries, however, may bear little relation to modern spatial communities, e.g. counties which have become partly

urbanised. Coordination of planning with central government may also be hampered where central and local government boundaries are inconsistent.

(b) functions -
The blurred distinction between local and central government roles in community services has been mentioned. With no direct statutory responsibility in this area - the 1977 Town and Country Planning Act is permissive rather than prescriptive with regard to social planning - an increased role may lead local authorities into competition with special purpose authorities. Local authorities might find it difficult to promote community and preventive approaches in the interest areas of hospital and education boards. Social planning cannot be carried out effectively unless services such as health and education, so central to well-being, are fully covered.

The boundaries of responsibility and decision-making amongst all these organisations is unclear. As an example, the Department of Health's discussion document on area health board legislation acknowledges the need for these boards to take note of regional planning schemes, but does not discuss any methods for joint health service planning with regional or united councils.[29] Furthermore, it is the hospital boards which are to decide whether or not an area health board will be established. Perhaps more important than overlap, is the problem of gaps in services due to the lack of defined responsibility. This was exemplified by the recent decision of the Papakura City Council to withdraw its emergency housing service as it was seen as a central government responsibility. It could be argued that the present difficulties small, locally-based groups and local authorities themselves have in obtaining funding and the relatively undeveloped nature

29. Health Services Reorganisation - A Discussion Document, Department of Health, 1982

of community services in New Zealand arise from the lack of defined responsibility in this area.

(c) funding -

Territorial local authorities have their own funding base through rating. There is a strong feeling, however, that this is acceptable for provision of physical services only.

> *"A charge on property was entirely appropriate when local government was involved almost exclusively with servicing properties; the dramatic change in the functions of local government over the last two decades from servicing property to servicing people has imposed a very severe burden on the property owner ..." 30*

Present funds supplied by central government to local authorities are generally in the form of specific and well-controlled subsidies for recreation, urban renewal, community facilities or community workers, for example. Little progress has been made in discussions on revenue sharing, and it is unlikely funds will be released without specific tags for purposes of accountability. This view was confirmed by the New Zealand Council of Social Services in their discussion on the difficulties inherent in directly assisting local development. They saw scope for greater regionalisation of resource allocation within departments and with the Lottery Board as well as a better consultative service.[31]

(d) accountability -

Local authority members are elected and thus are subject to regular scrutiny by their constituents. The current structure of local government means that the opportunity to stand for election is not equally open to everyone. Local politicians are paid only meeting fees (whereas MPs are on full salaries, plus expenses), meetings are held in

30. Municipal Association President's Report, 1981

31. Funding for Voluntary Welfare Organisations, NZCOSS - unpublished response to a request from the Minister of Social Welfare, 1982

working hours and workloads are heavy. This means elected councillors tend to over-represent certain sectors of the populace (the business community tends to be far better represented than manual workers). It is not uncommon to find councillors' residences concentrated in just a few areas. Less than half of local councils have voting on a ward system, where councillors are obliged to live in the areas they represent.

Conservatism is a strong characteristic of much of New Zealand's local government (on the part of both politicians and officials), and the needs of disadvantaged groups will not necessarily be heard by local government even if it is closer to grass-roots. (The treatment of blacks in the southern USA before federal intervention in the 1960s is a dramatic example of this effect.) Innovation may flourish more easily in central government which is open to influence from other countries. Similarly, there is no guarantee local government will be less bureaucratic and more approachable than central government.

Developments in some local authorities indicate scope for their role in the promotion of local initiatives and services. However, concerns for adequate representation, accountability, autonomy and sufficient funding need to be addressed if decisions on services are to represent the wishes of the areas.

An underlying dilemma is that unless local government is given greater power, autonomy and control over a larger slice of financial resources, it is unlikely to develop a structure equipped to undertake and promote community development and community-based services. But, until local government shows an ability and willingness to take

such initiatives, it seems central government will be unwilling to devolve further power and resources.

> *"... in the area of social services, as in other aspects of national development, there is unlikely to be substantial development in the direction of decentralisation without the development of a stronger and more rational structure of local and regional government able to assume greater responsibility in the allocation of resources."*[32]

3.4 Central Government

As well as providing the bulk of funds for social services, central government policies concerning the levels of benefits, grants, funding programmes and regulation have a pervasive influence on the initiatives of local government, voluntary groups and informal systems of care.

The concept of community-based services has been interpreted in various ways by central government policy-makers:

(a) A lesser role for the state as provider of services and a movement towards commercial, voluntary and informal sectors. Essentially this is the privatisation of service delivery and is manifest as the reduction of state provision, subsidisation of other service providers or changes in regulation.

(b) A need to decentralise and diversify its own services. This has included an emphasis on smaller, less institutional bases for services and consequently less institutional buildings and facilities, greater emphasis on workers in the field and participation in decision-making.

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32. New Zealand at the Turning Point, Task Force on Economic and Social Planning, December 1976, p.112

The privatisation of service delivery

The state's role in subsidising other groups to provide services is not new. However, indications are that the encouragement of 'community' rather than 'state' services is becoming clearer as a policy objective.

Subsidy schemes which encourage non-governmental groups to provide services include provision by private enterprise (hospitals, consultants), professional non-profit ventures (Red Cross, Plunket, Barnardos), and organisations operating predominantly with unpaid or partially paid volunteers (Citizens Advice Bureaux, Youthline, Women's Refuges).

Subsidies to voluntary organisations and private enterprise enable more provision for less public outlay. Yet subsidies to private hospitals and tax exemptions for medical insurance have encouraged such a growth of private health provision, that resources for public health are reduced and public services could be eroded. Private provision, in particular, tends to result in services for the better off. Thus despite the attractiveness of flexible, market-based services, their growth may perpetuate inequities of access. Though the role of private enterprise is increasing in the health sector, the integration of schools is reducing its contribution in education.

The impact of subsidies on the voluntary sector has been discussed in Section 3.2. It remains to note that while more opportunities have been provided for voluntary groups to become involved, there has not been a uniform emphasis on subsidising groups or schemes which are participatory and locally-based. There are wide variations in policy: the Education Department subsidises few voluntary or private groups, the Departments of Health and Social Welfare emphasise their own criteria and objectives, the Departments of Internal Affairs and Maori Affairs are more concerned with the process of development within specific communities.

Central government sources designed to facilitate community-based schemes include Internal Affairs, the Lottery Board, small general purpose funds within most social service departments, and the schemes of the Department of Maori Affairs. Despite widespread support for the idea of 'community' services, the funds available do not appear to have increased in real terms. The programmes of the Department of Internal Affairs and the distribution committees of the Lottery Board are wide-reaching. A large proportion of their funding is destined for recreation, art, sport, and employment rather than social service activities. The proportion of lottery funds going to the welfare services distribution committee actually dropped in the period from 1981/82 to 1982/83 (15 percent to 12 percent). The $1 per capita available to groups through local bodies in the Local Community Development and Recreation fund has not increased for several years. There is also a tendency for these funds for community development or community services to be used by local authorities or quasi-governmental bodies (such as the National Water Safety Council), rather than autonomous local groups. The same tendency was noted with 'community health' funds, which were often picked up by hospital boards for extensions to domiciliary services or the development of outposts. In Internal Affairs programmes, seeding money is more common than permanent finance. Intended to prevent dependence and ensure flexible use of funds, this creates difficulties for activities needing on-going subsidies.

Changes in legislation can also shift responsibility between the government and other sectors. The decriminalisation of drunkenness means police can no longer arrest on this basis alone. Those who were previously candidates for prison cells are now increasing the demand for night shelters. The needs of refugees currently arriving in New Zealand are predominantly provided for by the voluntary sector as there has been a very limited response from central government. The reduction in state rental housing is another policy change which puts pressure on other sectors. The need for emergency housing is now felt throughout the country.

The current economic recession and resultant cuts in budgets for social services (with the exceptions of transfer payments and Department of Labour employment and training schemes) have made it particularly difficult to support movements towards community services which generally require the extraction of funds from traditional areas. Lack of coordination among the central government agencies which fund community services and a tendency to respond to crises rather than establish a balance between ameliorative and preventive or promotive work, is also evident. Programmes with short-term visible benefits tend to win out over long-term developments. In political terms, striking this balance may be difficult. Demands for government to intervene in a life and death situation (assistance to a young boy needing a specialist operation overseas is a recent example), to ease the financial crisis of an established voluntary organisation, or to set up new services in response to effective interest group demand (Rural Education Action Programmes), may impede a more rational planning process.

Decentralisation of government services

The main features of decentralisation within the social service departments are the greater reliance on outreach offices or smaller less institutional settings and the increasing use of field officers or community workers. The rationale for this, stated in policy objectives, includes the desirability of flexibility, participation and responsiveness to diversity. As mentioned in earlier sections, merely shifting the base of a service is not sufficient to ensure the participation of, let alone accountability to, clients or the wider community. This is important in assessing the impact of decentralising moves made by central government.

This trend towards decentralisation has been strong in the health area. Several locally-based family health counselling services under the authority of the hospital boards were initiated early in 1977, and later that year funds earmarked

for community health projects became available (this special funding was discontinued in 1981). In both cases some of the resulting projects were jointly sponsored with voluntary organisations, others being the responsibility of a hospital board or the Health Department. Expansion of domiciliary services, Meals on Wheels, home help and specialist nursing care, and extra-mural psychiatric services resulted, along with some more innovative programmes such as the Porirua community health project.

The Department of Maori Affairs has moved towards decentralisation. The 'tu tangata' philosophy incorporates the people as initiators of their own development and, in concept, the recent reorganisation places the Maori people at the top determining the development policies to be enacted by the department. The ultimate statutory authority, and the maintenance of devolved decision-making, however, lies with the department.

The department's change of administrative style is reflected in the Kokiri Unit, where district office staff operate under the umbrella of kokiri community management groups which set priorities in their area. These units are gradually being established throughout the country at the discretion of Maori leaders. The kokiri management committees comprise elected representatives of Maori communities and include single and multiple Maori tribal groups and Pacific Island interests. There is representation from the local district office of the Department of Maori Affairs. Activities include school visits, assistance to job seekers, fostering the Maori language and support in courts.

In some districts the social and community development programmes of the department have been subsumed under the control of the kokiri management committees. These include Kohanga Reo (pre-school language 'nests') and Rapu Mahi (job search schemes). The re-organisation has required both that officers of the

department attend meetings at marae, and the people in Maori communities become involved in the programmes. However, concern for accountability still requires policy and issues of funding to be approved by central government. Whilst the new programmes and approach have been enthusiastically received in many areas, there is also concern about the speed with which changes have occurred and the uneven development of programmes. Reasons for the lack of preparedness of some Maori communities to take such a responsibility are unclear at this stage, but perhaps indicate the difficulties people have in taking an active role in decision-making after a long period of centralised control.

Other decentralised services have openly exhibited tensions concerning decision-making and accountability. The Mt Albert centre for mental health care is an example. A community mental health facility with 'beer and baccy' funding, it was established as an outreach of Carrington Hospital, providing mental health services on a local level. The centre's staff surveyed residents in an attempt to identify local needs. A number of community-based programmes, including drop-in centres, were set up in response to the needs demonstrated. This development raised questions as to whether the centre was meeting its commitment to the community to the neglect of that to the hospital. Debate ensued as to whether a community-based service can operate autonomously and move in the direction dictated by the needs of the community, and at the same time, remain accountable to a hospital service which is primarily charged with the diagnosis and treatment of ill health.[33]

Schemes designed to enhance community responsiveness and flexibility by drawing in local people are exemplified by the Education Department's Rural Education Activities Programme

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33. Mintoff, B., Quinlan, J., Dowland, J., Barrer, B., Mt Albert Centre for Mental Health Care - A Planning and Assessment Exercise, MSRU Department of Health, Occasional Paper No. 23, Wellington, 1983

(REAP) and Community Education Initiatives Scheme (CEIS). In both cases there are locally-based management groups drawing in a mix of elected and appointed members.

The CEIS programme is targeted to meet the needs of 'at risk' youth. The education personnel operate with a community development focus. They facilitate the coordination of local resources in the promotion of education geared in particular to life and employment skills. The schemes operate in three areas - Inner City Auckland, Otara and Flaxmere (Hawkes Bay). Each is controlled by a local committee and has its own aims and objectives.

REAP's basic provision is extra teaching staff in rural areas. While the management committees determine the use of staff, it is worth noting that the Wairarapa scheme, which merged with the Community Action Programme (CAP) that had been operating for several years, has more autonomy and flexibility than the other programmes.

The introduction of population-based funding for hospital boards has also been an approach toward the decentralisation of decision-making. Previously hospital boards applied to the Department of Health for much of their funding, resulting in regional inequities (some hospital boards were more active in this process than others). The Department of Health retained control over the approval process. Now hospital boards will receive lump sum grants based on population and set their own priorities for hospital facilities and community health programmes. This may in fact be detrimental to community health projects as they are now directly in competition with the needs of hospitals, with decisions being made in a 'hospital' environment. Evidence suggests a bias in favour of institutionalised and specialised services:

> *"There is a belief that when there is competition for resources the more powerful and longer-established sectors of services, the high technology specialities and the*

> *institutionally-based services will be more successful than community services, primary health care and long-term care services. The limited evidence available indicates that this concern is justified and that over the last decade explicit policies to allocate resources to community groups have not been particularly successful."*[34]

On the other hand, consumer groups and the public in general may be able to lobby more effectively on priorities for health spending in their regions.

There have been several different approaches to the placement of field workers. The Department of Social Welfare has 14 new positions for 'employment-related' social workers who work in the field, predominantly with 'at risk' youth. Assisted by a small funding resource, they are employed by, and accountable to, their district offices.

The Department of Labour has employed people with relevant community and practical experience to work as Group Employment Liaison Scheme fieldworkers in areas of high unemployment. Their task is to liaise between groups of unemployed and the bureaucracy to ensure better use is made of government's various employment and training schemes. The fieldworkers are encouraged to comment directly to head office on the effectiveness of the various programmes that exist. They are responsible to the Chief Executive Officer (GELS) at head office.

The former approach links the advantage of strengthening action at the district office level with the disadvantages associated with conservatism and entrenched attitudes in many areas. The GELS workers have free movement in their regions which may enable them to work more effectively and be more responsive to head office philosophy. At the same time resentment may develop in the district offices which, in response to the rapid growth of unemployment, have had to be responsible for a wide range of employment programmes but lack control over GELS officers.

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34. Barnett, P., and Goodall, M., "Issues and Conflicts in Health and Welfare Provision", Canterbury at the Crossroads, NZ Geographical Society, 1983

The Department of Maori Affairs and Internal Affairs have both put more emphasis on funding personnel who are directly accountable to groups in the community. In the Department of Maori Affairs district office staff are accountable to community management groups. The Department of Internal Affairs subsidises community workers in local authorities and detached youth workers who operate in association with a community organisation and are considered accountable to the community they work in.

3.5 Other Groups

The Planning Council and others have suggested institutions such as unions and employers could take more responsibility for social service provision.[35] At present their welfare roles are centred firmly on the workplace, which is generally, physically as well as functionally, separate from workers' residences.

The direct impact of unions on services within communities is minimal. Recently there have been moves to set up medical insurance schemes for union members through commercial firms. Some of the larger unions, such as the Public Service Association, provide members with subsidies for certain services. Unions vary greatly in the resources they have available and in how they are used. Most of their efforts centre on employment conditions and, with the onset of voluntary unionism, it seems unlikely unions will be sufficiently well-resourced to expand their services further.

Employers are asked to contribute directly to social services through Accident Compensation Corporation levies. Many large employers supply welfare and recreational services. Industrial chaplaincy, generally a cooperative venture amongst employers,

35. See for example Directions, New Zealand Planning Council, 1981, and more recently, Minister of National Development, The National Development Strategy, 1983, p.24

workers and churches, is a growing means of providing care for workers themselves and their families. As well as being voluntary, and uneven in their effect, such initiatives again have minimal impact in suburban communities. The Johnsonville study showed the lack of interest local business people and retailers had in improving community facilities. Whereas it has become common for soccer teams and racing yachts to receive corporate sponsorship in return for advertising, pre-school playgroups and drop-in centres for the elderly have yet to be seen as attractive sponsorship prospects!

Section 4

THE ISSUES

The discussion in Section 2 outlined the range of possible approaches to community involvement through the various processes of community development and public participation. Section 3 then described some of the activities of groups and organisations involved in care and services, that have been seen as trends towards community-based delivery or community involvement. The diversity of approaches, and lack of clear definitions, preclude any meaningful analysis of these activities as a whole. There are, however, common themes or values emerging in the developments occurring under the 'community-based' label. They include a belief in the value of client involvement, the importance of independence rather than dependence, preference for prevention rather than cure, flexibility rather than uniformity, and the desirability of fostering the development of communities and encouraging them to be actively involved in meeting their own needs.

Limitations on the development of community services have already been illustrated. It has also been shown that a move away from direct central government provision cannot of itself be assumed to achieve the above objectives. These factors raise underlying issues related to power over decision-making, equity and the evaluation of social services.

4.1 Power over Decision-making

Much state intervention in the social service arena arises out of a concern to meet basic needs or establish uniform standards (in education, hospital services, for example) and the protection of individual rights. This intervention carries with it elements of social control - education is compulsory, the protection of citizens includes intervention by health and welfare professionals in family situations. In a comprehensive

welfare state where centralisation and uniformity are emphasised, the needs of individuals, families and households are defined for them by government. People are told what they should use in the way of educational, medical and other services and are provided with sustenance in times of crisis and at periods of their life when they may be particularly vulnerable. Given such an approach over several generations, it is no wonder people have become conditioned to look to the state to fulfil every need as it arises. If people are dictated to, are told what is good for them, are not allowed to have control over their own lives, it is not unexpected that they will become dependent on the source of instruction and benefit. This dependency has implications for decentralised decision-making.

The advocates of a more community-centred approach to service delivery favour more self-reliance. Yet dependency cannot easily be broken. Community workers often report the lack of activism and individual powerlessness, particularly amongst disadvantaged groups. The predominance of white, professional men as 'community' representatives in a variety of governmental and non-governmental organisations, attests to the unequal distribution of existing 'community' power. Redressing this balance is likely to be difficult and time-consuming, particularly in areas where there are wide disparities in income, education and lifestyles.

Even if communities have the capability of taking over and running services, they frequently do not have the resources required. Centralisation of power has been accompanied by strong centralisation of control over resources. How can community initiatives be supported without their being controlled? How can they be made responsive to local needs while still being accountable for the use of resources provided centrally? The discussion on informal care within communities suggests there are definite limits to the ability and willingness of families and volunteers to provide more care.

Devolution of decision-making also implies the challenging of traditional power bases. Retention of power is related to self-interest and to the preservation of the benefits and privileges power and control bring.

However, power-sharing may also be resisted for other less selfish reasons. The value systems of those who have power prescribe what is 'correct' behaviour, and control is used to limit behavioural alternatives and to provide rewards and punishments which encourage 'correct' behaviour or return persons to what is defined as normality. Power and control are thus used to enforce rightness which is sincerely and unquestioningly believed in. Definitions of 'correct' behaviour do change over time; different attitudes have been taken to the participation of women/married women/mothers in the paid workforce over the course of this century. In this way, through the medium of a set of values, power may be exercised unconsciously. People who have power and exercise control may talk about 'doing good' and 'helping people'. This is related to the persistent categorisation of the 'deserving' and the 'undeserving' poor, and the feeling that people cannot be trusted to know what is best for them, a sentiment underlying much thinking about social policy.

While there are obvious advantages in greater devolution of power and the lessening of central control, it is extremely difficult to work out the mechanics of devolution. There is fragmentation both in the way needs are expressed and in how they are met. Specialisation of government departments leads to specialisation of delivery agencies and hence of the interest groups which lobby them. This fragments and disperses both power and decision-making. The degree of devolution accepted by a service agency will depend on the attitudes of those in control (the hierarchy of the Department of Maori Affairs has seemed willing to allow a considerable degree of devolution). The strength of community action pressing for perceived rights or needs also suggests a tension between funders and the process of decision-making.

If workers and groups in the community are accountable to those communities, what are their responsibilities to the providers of outside resources (e.g. central government)? In non-money terms, accountability to a local community is a powerful sanction, but there must also be concern for the taxpayers and their interests. Devolution of revenue collection, and responsibility for its distribution is an inevitable consequence of true devolution of decision-making but implies a real loss of central control.

In the New Zealand context, where many major voluntary organisations are closely tied to the government establishment (Plunket, Marriage Guidance, Society for the Intellectually Handicapped, etc), it seems unlikely that increasing the role of voluntary agencies will increase participation in services. While government may feel comfortable in giving such bodies freedom to deal with large amounts of money by way of subsidies, they are not accountable to taxpayers or even consumers in some instances. There are also indications that these bodies establish trust through conformity with the values of those who wield power over resources and that there is not always scope for grassroots involvement, diversity or innovation.[36]

Uneven representation on local authorities suggests a need for better methods of participation at this level. Whilst councillors and board members are directly accountable to constituents through elections, their base may still appear centralised and distant to groups operating or vying for support at a neighbourhood level.

Power over decisions in the social services is often held by professionals - doctors, judges, psychiatrists, teachers - and professional groups stress the importance of adequate training and the maintenance of standards. They have, however, frequently been charged with withholding decision-making power from non-professionals and consumers. This means that the

36. This was noted in Who Makes Social Policy?, NZPC, 1982

consumer is severely limited in the choice of service and that the professional is more likely to fit the client to the model s/he operates than to respond to the client's assessment of need, e.g. if one approaches a medical doctor with a problem, the sickness model will be applied and will determine the action to be taken - drugs are likely to be prescribed for sleep disturbance even if this is caused by interpersonal conflict. Reliance on professional judgement can thus accentuate 'powerlessness' and dependency. Professions often tend to defend their territory and use their power to deter competition and maintain income and status. Self-help and consumer involvement may threaten this. Where low income is seen as a problem in itself, for example, client participation in decision-making is more likely to lead to demands for extra income rather than professional services such as counselling.

Even so, the principles of self-help and participatory views of democracy have encouraged significant, though uneven, moves towards enabling greater client participation in decision-making. More and more professionals recognise the value of consumer education, if not consumer participation, in social services.

If there were greater diversity in service provision, this would increase choice for the consumer, but would reduce the control which could be applied by professionals and by the power structure to which they are generally aligned.

4.2 Equity

Two main equity considerations arise out of present systems of social service delivery and the proposals for a greater emphasis on community involvement in services. They are equity in access and in contribution to services and care.

Equity in access

Differential gains from social services between groups in society (comparisons of Maori and pakeha health and education achievements

provide a dramatic example of this) suggest deep-seated social inequalities operate to influence how services are used and benefit derived. Le Grand talks of the middle class 'capturing' social services and has defined public expenditure as:

> *"a device through which the better off use the general body of taxpayers to fund consumption of a service that they would have purchased anyhow, but which otherwise they would have had to pay for directly."*[37]

It is difficult to measure the impact of social services on groups within society and very little work of this nature has been done in New Zealand. The Royal Commission of Inquiry into Social Security (1972) concluded from its study that the tax, social security and social services had relatively neutral redistribution effects except at very low income levels, at that time.[38]

This issue affects not only direct access to services but also access to employment in the social services. The emphasis on employment of educated professionals has not only led to higher socio-economic status for these groups but accentuates the class differences between professionals and clients.

It is postulated that an emphasis on self-help, participation, and diversity of services at the community level could lessen those problems of access which result from alienation or class differences. Te Kohanga Reo is an example. More participation and self-help require greater input from clients however, and the lower income, less educated groups generally have less time and fewer influential contacts to ensure their particular needs are met. The possibility of greater inequality with more 'community-based' services is very real.

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37. Le Grand, J., The Strategy of Equality: Redistribution and the Social Services, George Allen and Unwin, 1982

38. Social Security in New Zealand, Report of the Royal Commission of Inquiry, March 1972

Areas which find it easier to provide resources and to become organised are likely to achieve a higher level of service provision than areas which lack resources and people. In negotiations between local authorities and central government, between neighbourhoods and a local council, the competing protagonists are demonstrably unequal in the influence they wield and the resources they can bring to bear. Harvey asks which is likely to enhance social justice? - centralisation of resource distribution which can attempt a fair division, or decentralisation, which would reduce the influence of stronger units, giving the weaker more autonomy even if their shares were smaller.[39]

Just as Harvey doubts whether greater dependence on market principles would achieve greater equity and whether the free movement of capital can achieve spatial justice (because capital will flow to the areas of greatest opportunity, not of greatest need), he also feels that resources for community development may tend, unless principles of equity are more stringently applied, to flow to areas with the greater political expertise and knowledge and to groups which have the greatest affinity with the decision-makers and resource controllers.

Equity in contribution

There is no definitive view of what would be a 'fair' contribution to social service costs by those who use them directly, or to the relative responsibilities of individuals, families and the state in their provision. An emphasis on 'community-based' services implies some shifting in contribution levels, yet it cannot be assumed that this will be a move towards a more equitable loading.

Whilst a lesser role for centralised, uniform and specialised services suggests a greater availability of resources for other

39. Harvey, D., Social Justice and the City, Edward Arnold, London, 1973

forms of service and care, there is not a clear shift of resources in this direction. The bulk of funds for non-governmental services go to well-established, nationally-organised groups or those providing institutional care. Policies for use of funds are still determined within government. There is fierce competition for more flexible funding sources.

Moreover, several new policies rely on a greater role by voluntary groups and volunteers in service provision. There are no obvious indications that volunteers and voluntary agencies are willing or able to pick up many more responsibilities without financial or advisory support. Traditionally, voluntary work in welfare services has been the domain of white middle class women. This has reinforced a welfare approach to social services as other groups within society lack the required time and money to engage in this activity.

Many women are now questioning their traditional role as unpaid nurturers within families and the wider community and are tending to help themselves by moving into employment or further education. The growing emphasis on training programmes for volunteers provides an incentive for those who wish to use voluntary work as a stepping-stone to a paid career. However, it is only the well-resourced agencies which can offer extensive training (the Department of Social Welfare not only trains its volunteers, but also pays a travel allowance), and these agencies may siphon volunteers off from other more informal activities within communities.

4.3 Evaluation of Social Services

Concern for efficiency in social service expenditure has been behind much of the support for community-based services with their presumed benefits of effectiveness, economy, social benefit, participation and scope for prevention.

There is obviously no simple way to evaluate social services, nor does there appear to be any objective way to rank priorities. Ideological differences underlie evaluation difficulties. Concepts such as effectiveness and accountability take on different meanings depending on whether social services are intended to do something for people, to return them to 'normality', or, on the other hand, are seen as seeking to allow people to participate in service delivery, to define their own needs and ways of meeting them.

Difficulties in evaluation are exacerbated where services emphasise local participation, self-help or community development. Participation and self-help can be seen as objectives in themselves - expressing a view of democracy and human development that is inherently valuable and part of a 'better' society. An alternative view stresses the role of participatory and self-help techniques in decreasing dependency on central government and increasing self-reliance within communities.

Different perceptions of need and its causes lead to different perceptions of effectiveness. Clients, voluntary workers, unpaid carers, social service agencies and the general public are likely to have quite different solutions to specific problems. Homelessness, for example, may be seen as the need for housing or as a consequence of other needs - employment, income maintenance, changes in building regulations or loans policies, consumer education.

Varying definitions of need and how it can be met are not a problem where services are autonomous and self-funded. However, given the limits on groups within communities to develop their own services without outside funding, tension often arises between the objectives of the locally-based group and that of the funding body.

Traditional evaluation techniques, emphasising the measurement of costs and benefits, have limited value in the social service area.

Some services, such as the treatment of injuries, yield definite results in the short term which can be measured, costed and compared with alternative services - all of which have the same objective. Others, such as community centres, have more indirect impacts that are less easily measured or extend beyond the stated objectives and there are no obvious alternative services with which to compare costs.

A wider perspective on evaluation is essential if community group activities and developmental work are to compete more effectively for social service resources. Progress has already been made in this direction with several programmes stressing monitoring and on-going evaluation. The recent evaluation of the Detached Youth Worker Funding Scheme recognised the importance of working with individuals and groups to help them take more control over their lives, bring about changes and set up permanent solutions to their problems. It also recommended that projects incorporating such a developmental approach have preference for funding under this scheme.[40]

40. Detached Youth Worker Funding Scheme Evaluation Working Group, An Evaluation of the Detached Youth Worker Funding Scheme, February 1984

Section 5

CONCLUSION

A wide range of activities and policies have been included under the heading community-based services and community involvement in service delivery and there are many definitions of, and approaches to, community development. These must be seen in relation to the wider issue of the role and objectives of the welfare state. If emphasis is laid on encouraging families and non-governmental groups to provide increasing amounts of care, thus reducing dependence on central government, then this suggests that the state's role in service delivery is residual - or as a provider of last resort. An alternative view, however, is to see public participation in service planning and community development as essential elements of the welfare state in modern society, providing services from which all may benefit.

There will always be a need for specialised institutional care, crisis intervention, and work to prevent conditions which precipitate such need. Central government, as legislator, and as a provider and funder of social services, has a major influence on their shape and operation, and cannot be reduced to a residual role in service delivery. If improvements in general well-being are to be achieved, clearly stated social policy objectives matched by appropriate funding and support systems, and legislation, are required.

Recognition of the nature and inter-relationships of the groups involved in meeting needs - family, neighbourhood and interest groups, commercial agencies, voluntary organisations, local and central government - is a precursor to planning by central government. None of these groups of themselves have the resources or ability to cater for the wide range of individual or community needs, and most rely on external funding or other assistance to achieve their goals. A greater role for non-governmental groups

in service delivery will certainly alter the nature of demand for centrally-provided services, but it is unrealistic to assume that total demand on the state will be automatically reduced.

The groups which provide services and care have different strengths and weaknesses, and some are more appropriate in meeting specific needs than others. Families and local networks may be the best agents to alleviate loneliness; central government institutions have the resources and expertise to provide specialist remedial care. Moreover, families, self-help and community groups are often in a better position to recognise needs and effective ways to meet them than centralised agencies, either state or voluntary. This is borne out by the difficulties of ensuring equity in access to, and outcome from, centralised services. Contrast this with examples of successful programmes which emphasise self-help and participation.

The recognition and acceptance of diversity within society is essential to an increase in client participation, and community work which aims to stimulate consumer definition of need and the development of more appropriate services. This implies a lessening of direct government control over service design and delivery, which may not be easy to achieve. At the same time local authorities, voluntary agencies and community groups must be encouraged, if not required, to become more accountable to those they work with and for.

There are obvious tensions involved in encouraging the development of services that are accountable to consumers. Concerns for spatial equity, professional standards, social control, accountability to taxpayers, special attention for disadvantaged groups or areas, can all limit consumer involvement in services. Thus it is not surprising that the majority of programmes which do incorporate client participation have stressed cultural,

recreational or employment activities, or have been peripheral to mainstream services such as health or education.

Consumer involvement should be encouraged for ideological reasons as a recognition of people's right to participate and to be in control of their lives, and as an antidote to dependency. It has other advantages - it is a way to make services more appropriate and to ensure more equitable access to them, and can also provide a means of evaluating services from a consumer viewpoint. There are many policy changes which could assist in this process, such as the placement or identification of people in the community who could act as mediators between the community and service institutions, to begin to foster better inter-relationships, understanding and a two-way flow of information. Community workers, community leaders and social planners could fill this role. Central government agencies could re-evaluate their funding policies to give greater recognition to on-going funding for community initiatives (especially funding for personnel), more regular and substantial support for volunteers, and to explore ways whereby government and non-government agencies could jointly evaluate services. If local authorities had a greater role in the distribution of funds for social services, this could reduce the difficulties which locally-based and locally-focused groups have, in comparison to those which are nationally-based. There is also scope for non-governmental groups to be more actively involved in the planning of services, and for central government to produce more coherent and better coordinated social policy initiatives. In addition, support which is expressed for the concept of 'community' involvement in social planning and service delivery needs to be reflected in much greater commitment to the principles of consumer participation and community development.

APPENDIX I

THREE MODELS OF COMMUNITY ORGANISATION PRACTICE
ACCORDING TO SELECTED PRACTICE VARIABLES

	MODEL A (Locality Development)	MODEL B (Social Planning)	MODEL C (Social Action)
1. Goal categories of community action	Self-help, community capacity and integration (process goals)	Problem-solving with regard to substantive community problems (task goals)	Shifting of power relationships and resources; basic institutional change (task or process goals)
2. Assumptions concerning community structure and problem conditions	Community eclipsed, anomie; lack of relationships and democratic problem solving capacities; static traditional community	Substantive social problems; mental and physical health, housing, recreation	Disadvantaged populations, social injustice, deprivation, inequity
3. Basic change strategy	Broad cross section of people involved in determining and solving their own problems	Fact-gathering about problems and decisions on the most rational course of action	Crystallisation of issues and organisation of people to take action against enemy targets
4. Characteristic change tactics and techniques	Consensus: communication among community groups and interests, group discussion	Consensus or conflict	Conflict or contest: confrontation, direct action, negotiation
5. Salient practitioner roles	Enabler-catalyst, coordinator; teacher of problem-solving skills and ethical values	Fact-gatherer and analyst, programme implementor, facilitator	Activist-advocate: agitator, broker, negotiator, partisan
6. Medium of change	Manipulation of small task-oriented groups	Manipulation of formal organisations and of data	Manipulation of mass organisations and political processes
7. Orientation toward power structure(s)	Members of power structure as collaborators in a common venture	Power structure as employers and sponsors	Power structure as external target of action: oppressors to be coerced or overturned
8. Boundary definition of the community client system or constituency	Total geographic community	Total community or community segment (including 'functional' community)	Community segment
9. Assumptions regarding interests of community subparts	Common interests or reconcilable differences	Interests reconcilable or in conflict	Conflicting interests which are not easily reconcilable: scarce resources
10. Conception of the public interest	Rationalist-unitary	Idealist-unitary	Realist-individualist
11. Conception of the client population or constituency	Citizens	Consumers	Victims
12. Conception of client role	Participants in interactional problem-solving process	Consumers or recipients	Employers, constituents, members

Source: Rothman, J., "Three Models of Community Organisation Practice", in 26-27, Cox., F., et al. Strategies of Community Organisation, Illinois, Peacock, 1974

APPENDIX II

EXAMPLES OF CENTRAL GOVERNMENT EXPENDITURE ON GRANTS AND SUBSIDIES TO NON-GOVERNMENTAL AGENCIES AND SERVICES IN 1982/83

Department of Social Welfare

Of the total budget ($3,700 million), the major portion was spent on income transfers (National Superannuation 65.4 percent, other benefits 28.3 percent). $79 million or 2.1 percent of the budget was spent on social work services. This included approximately $31.5 million on subsidies and grants to voluntary organisations, community groups and special aid to families or disabled people.

Department of Education

$12.7 million of grants and subsidies went to private schools (0.8 percent of the budget) with an extra $24.4 million of grants for integration within the state system. $4.3 million was granted to pre-schools (excluding the training and wages of kindergarten teachers). A further $6.2 million went to non-governmental or quasi-governmental groups involved in education. Most of these groups are nationally based - the largest grant of $2.7 million was received by the Royal New Zealand Foundation for the Blind.

Department of Internal Affairs

Nearly $12 million (0.15 percent of the budget) was spent directly on grants and subsidies for community development. Of this, $6.2 million went to nationally-based quasi-governmental organisations (NZ Authors Fund, NZ Literary Fund, Queen Elizabeth II Arts Council, NZ Film Commission, NZ Historic Places Trust, National Art Gallery and Museum, NZ Council for Recreation and Sport); $3.1 million to the recreation and community development scheme; $1.2 million to national and special projects, and smaller amounts for funding the detached youth worker scheme, Youth Initiatives Fund work development project scheme and the local authority recreation adviser scheme.

Department of Justice

From a total budget of $130.7 million, grants were made to the Marriage Guidance Service ($0.6 million), the Prisoners Aid and Rehabilitation Society ($0.3 million) and the Justices of the Peace Association.

Department of Maori Affairs

$6.3 million, nearly 10 percent of the total budget, was spent on community development. Of this $2.3 million was paid in grants and subsidies to national Maori organisations and community groups.

Department of Health*

The vast proportion of funds (74.3 percent of the budget) is committed to hospital services of which approximately 95 percent is for state provision. $32.3 million (1.8 percent)is earmarked for health promotion, of which $12.8 million is budgeted for the department's own public health nursing. The major recipients of grants and subsidies in the voluntary sector are the Plunket Society ($8.5 million), Children's Health Camp Boards ($3.1 million) and Family Planning Association ($2 million).

* 1983/84 Estimates

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